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AUTHOR Young, Steven C.

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ABSTRACT

This practicum report describes a project designed to increase the level of coordination of treatment planning between professional and paraprofessional staff at a residential treatment and educational facility for 40 adolescent males with learning disabilities or severe emotional disturbances. Three corollary aims were to increase the level of involvement by paraprofessional child care workers in the treatment planning process; to improve communication among the child care workers, professional clinicians, and teachers; and to improve the formal documentation of treatment decisions. Three interdisciplinary teams were formed, composed of staff from the facility's three departments (paraprofessional/milieu, clinical, and school). An interdisciplinary treatment plan was developed that included an assessment tool for identification of presenting problems and 30-day goal sheets for each department. Interviews with all staff members (N=47) were conducted to evaluate goal attainment. Additionally, 10 treatment plans were reviewed to evaluate the new recordkeeping format. Project evaluation indicated achievement of major goals. Only the goal of a reduced number of incident reports regarding client verbal abuse and disrespect of line staff was not achieved. Appendices include a treatment plan form and the questionnaires used to evaluate the project. Includes 37 references. (Author/DB)

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Improving the Coordination of Treatment Planning Between Professional and Paraprofessional Staff at a Residential Center for Adolescent Males by Implementing an Interdisciplinary Team Approach

by

Steven C. Young

Cluster 39

A Practicum I Report Presented to the
Ed.D. Program in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1991

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PRACTICUM APPROVAL SHEET

This practicum took place as described.

Verifier:

Robert DiStefano

Robert DiStefano

Executive Director

Title

P.O. Box 4550
Long Beach, California 90804

Address

This practicum report was submitted by Steven C. Young under the direction of the adviser listed below. It was submitted to the Ed.D. program in Early and Middle Childhood and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

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Date of Final
Approval of Report

Allen Fisher

Allen Fisher, Ed.D., Adviser

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ABSTRACT

Improving the Coordination of Treatment Planning Between Professional and Paraprofessional Staff at a Residential Center for Adolescent Males by Implementing an Interdisciplinary Team Approach. Young, Steven C., 1991: Practicum I Report, Nova University, Ed.D. Program in Early and Middle Childhood. Descriptors: Residential Centers/Foster Care/Milieu Therapy/Case Work/Counseling Techniques/Treatment Decisions/Treatment Planning/Treatment Goals/Behavioral Objectives/Counseling Objectives/Team Counseling/Conjoint Counseling

This practicum aimed at increasing the level of coordination of treatment planning between professional and paraprofessional staff at a residential facility for adolescent males. Three corollary aims were to increase the level of involvement by paraprofessional child care workers in the treatment planning process, to improve communication between the child care workers, professional clinicians, and teachers, and to improve the formal documentation of treatment decisions in a format that was timely and useful for all staff members providing treatment services.

Three interdisciplinary treatment teams were formed. The new teams consisted of members from each department (paraprofessional/milieu, clinical, and school). A new interdisciplinary treatment plan was developed that included an assessment tool for identification of presenting problems and 30 day goal sheets for each department. Data was collected from interviews with all staff members who participated in the practicum to determine if the goals of the practicum were achieved. A review of 10 treatment plans provided data to determine if the new interdisciplinary treatment plan provided timely and relevant information useful to all members participating in the project.

All three expected outcomes were reached successfully and even surpassed in three of the four goals. Only the goal of a reduced number of incident reports regarding client verbal abuse and disrespect of line staff was not achieved. The data from the practicum demonstrated the following: (a) the interdisciplinary team approach increased paraprofessional child care workers level of job satisfaction, and (b) the interdisciplinary team approach improved cooperation between staff members and diminished cross-purpose treatment planning.

Permission Statement

As a student in the Ed.D. Program in Early and Middle Childhood, I do give permission to Nova University to distribute copies of this practicum report on request from interested individuals. It is my understanding that Nova University will not charge for this dissemination except to cover the costs of microfiching, handling, and mailing of the materials

December 26, 1991
December 26, 1991

Steven C. Young

CHAPTER I

INTRODUCTION

Description of the Work Setting and Community

The work setting for Practicum I is a private, non-profit, residential center (group home). It is licensed by the State Department of Social Services and funded by Aid to Families with Dependent Children/Foster Care (AFDC/FC), a mixture of federal and state funds. The center owns and operates a private non-public school (NPS) that provides special educational services for residents who qualified as learning disabled (LD) or severely emotionally disturbed (SED).

The residential center is a division of a parent, non-profit corporation. The corporation's board of directors is comprised of 23 members of the community, including two members of the city council. The corporation also has a foster family program that provides foster home placements for more than 160 children in the community.

The center is located on one acre of residential property in the midst of a middle-class residential neighborhood. The city is the sixth largest in the state with a population of more than 600,000, in a county of more than 7,000,000 people. The city is a thriving community with major assets from an international harbor, a major naval base and shipyard, and one of the largest aerospace industries in the world. During the last decade, major redevelopment has brought new prosperity to the city, and the once abandoned, poverty-stricken downtown commercial center is now thriving with new industries and increasing job opportunities.

Writer's Work Setting and Role

The center employs 47 full-time staff members who provide residential treatment and special educational services for 40 adolescent boys. There are four full-time administrative positions, two full-time licensed professional clinicians, and two part-time professional clinical interns. The paraprofessional child care workers have bachelor degrees in behavioral or social sciences. The paraprofessional staff is divided into four categories: counseling team supervisor, assistant team supervisor, counselor II, and counselor I.

The paraprofessional staff is responsible for the daily supervision of the residents. Eleven paraprofessional child care workers are designated as caseload counselors with three to four residents assigned to each caseload. Caseload counselors are responsible for coordinating services for the residents assigned to their caseloads. They are directly supervised by three paraprofessional counseling team supervisors. The counseling team supervisors supervise the treatment teams with 13 to 14 residents in each group. Supervisors are required to have at least 2 years experience as child care workers, and they must be enrolled in a graduate program leading to a master's degree in a behavioral or social science. The center reimburses child care staff for tuition, fees, and books, based on the state university tuition and fee rates.

The non-public school (NPS) employs an administrator/ principal, a psychologist, a social worker (MSW), two secretaries, four teachers, three teacher assistants, and a part-time vocational education instructor. The principal and teachers have current state credentials to teach special education students. The teacher assistants have associate degrees. The center's maintenance supervisor also serves as the vocational education instructor at the school.

Residents are adolescent boys, ages 13 to 17. The residents are either dependents of family court or wards of juvenile court. Most residents have had multiple placement failures before placement at the residential center, and the average length of residential placement is 12 months.

Currently, 31 residents have families with which to be reunited after completion of the program. There are nine residents with no familial resources with which to be reunited, and they are enrolled in the center's emancipation program.

A peer-culture group model is at the center of the treatment program. The residents are divided into three treatment teams, with each team staffed by a paraprofessional child care workers. The treatment teams, consisting of paraprofessional treatment staff and the residents, meet each afternoon in accountability groups to discuss and evaluate residents' behavioral goals, statuses, privileges, and group problems.

The professional staff (clinicians and clinical interns) provide residents weekly individual counseling for issues best addressed in a private therapeutic setting, such as sexual molestation, physical abuse, and drug dependency. The clinicians and clinical interns also provide specialty groups throughout the week--family therapy, a group for physically/sexually abused and neglected youths, and a drug/alcohol awareness program. The center's psychiatrist provides psychiatric evaluations and monitors the use of psychotropic medications. All residents receive full psychological assessments with supplemental educational testing and evaluation.

The writer is the residential center's director, responsible directly to the corporation's executive director. The writer is responsible for all aspects of the program at the residential center, including education (the NPS); program design and development; development and implementations of treatment plans and treatment modalities; the recruitment, training and supervision of staff; the maintenance of a healthy, therapeutic environment in keeping with strict state, county, and local standards and regulations; and most importantly, residential milieu (resident/house culture) and staff morale.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

The major focus of the practicum was to address the lack of coordination between staff members of different departments in the development and implementation of treatment planning. The problem must be understood within the context of the administrative and treatment structure of the center.

The project site is a residential center for adolescent boys. The center emphasizes the need for decisions to be made at the most common level of staff-resident contact. All other services are supportive in nature. To accommodate this emphasis, a strict division of labor has been established. The paraprofessional child care workers, who having most of the contact with residents, make basic decisions regarding resident behavioral goals, statuses, privileges within the group and at the center, home passes, etc. The three paraprofessional counseling team supervisors are responsible for all treatment services provided to the residents in the three treatment teams. Thus, there is one staff member who is directly responsible for every treatment decision for every resident at the center.

The clinical staff provides individual counseling and specialty groups. They do not participate in the status evaluation of residents or make any contribution in deciding discipline and privileges. By not being directly involved in resident evaluation and decisions regarding discipline and privileges, the clinicians are free to talk with the residents about any problems or concerns without the residents fearing the possible lose of privileges.

In analyzing the difference between the center's primary goal of coordinating departmental treatment planning and the problem of poor communication and cooperation between departments that prevented a unified treatment strategy, three distinct discrepancies between what was happening and what should be happening were acknowledged as the focus of the practicum:
(1) paraprofessional staff frustration; (2) the lack of coordinated treatment strategy; and (3) treatment plans that did not reflect current needs and treatment goals, and a coordinated interdepartmental treatment planning.

1. The paraprofessional child care workers were isolation from the formal treatment planning process. The residents attend group sessions each afternoon for 1 1/2 hours.

Status evaluation, behavioral goals, and individual/group problems are addressed during these groups. The focus is on group accountability. The child care workers and the residents make basic decisions regarding resident status, privileges, and group-sanctioned discipline. Both staff and residents have an equal vote for all decisions about the group as a whole or for an individual within the group. Each issue is discussed and evaluated within a prescribed format. The group format allows for the clarification of the issue before group discussion, positive and negative feedback by staff and residents to the individual(s) involved in the issue, and problem resolution through group consensus. The center's program emphasizes the need for residents to participate in a decision-making process with the paraprofessional staff who have daily contact with them. This is a powerful incentive for residents to hear the opinions, feelings, and judgments of peers and adults.

The center's primary belief is that treatment decisions must be made at the most common level of staff/ resident interaction. By design, the group model used at the center for many years provides added strength to the position of the child care workers. However, the child care workers still experienced frustration because they lacked input into the formal treatment planning process. The formal milieu treatment plans were devised and updated by the counseling team supervisors with input from administrative and clinical staff. The child care workers rarely knew the specific treatment objectives stated on the treatment plans. They felt as though their opinions about treatment goals were not appreciated by the supervisory, administrative, and professional (clinical) staff who were primarily responsible for the development of these plans. They were not invested in following through with specific treatment strategies.

Because of paraprofessional staff frustration, the center adopted the concept of caseload counselor. Eleven child care workers were assigned limited caseloads to meet the basic, daily, and changing needs of three to four residents. In the role as caseload counselors, the child care workers have regular input into basic treatment decisions.

Although the caseload counselor concept had a positive effect by helping child care workers become part of the treatment team with decision-making authority, it was far short of anticipated outcome. The child care workers did not participate in the formal treatment planning process or in the development of treatment plans. Their isolation from the process was frustrating, and this frustration was not fully mitigated by previous solutions.

2. The second discrepancy addressed by the practicum was

the lack of communication between the professional, the paraprofessional counseling team supervisors and child care workers, and the staff at the non-public school. The lack of coordination between the staff in each of these departments has resulted in frustration, cross-purpose planning in providing services to residents, and residents not receiving the best possible treatment services.

Because of the separation of the clinical and paraprofessional departments, residents were free to deal with very sensitive issues outside the group process without fear of losing privileges. Clinicians had nothing to say about statuses, privilege, or group activities. In like manner, school goals were separated from clinical and residential goals. With this separation of services, a resident failing in one area of the program may find success in another.

But the separation of services was often frustrating to staff members. Cross-purpose treatment planning added to the confusion. The paraprofessional treatment teams were responsible for the basic milieu treatment plans, which were designed to document long and short-term goals. The clinicians had a separate clinical plan for each resident, which recorded clinical treatment goals. And the school had a third plan with educational/vocational goals. The idea of separating services by departments seemed sound when the center originally added clinical staff and the non-public school to the residential program, but the result has been confusion and frustration.

To alleviate some frustration, clinicians were assigned caseloads parallel to the treatment teams. The hope was that by providing clinical services to the same residents on a treatment team supervised by paraprofessional staff, communication between the two departments would improve. The goal was partially obtained. The clinicians provided individual and family therapy for the same group of residents assigned to a particular treatment team. The clinicians had to deal with one paraprofessional supervisor and one set of counseling staff instead of three supervisors and three groups of staff. This resulted in improved communication and coordination of services between the professional and paraprofessional staff. Yet, there was still much frustration for both the professional and paraprofessional staff members, and specific treatment goals devised by individual departments lacked proper coordination with other departments.

The staff at the school was not part of this process. Informal communication between teachers and the residential supervisors and clinicians developed into poorly coordinated treatment planning. The school program and educational goals were virtually independent and isolated from the treatment goals developed and implemented at the residential center.

3. The third discrepancy addressed by the practicum was the inadequate format for review and revision of treatment plans. Individual resident treatment plans were reviewed once every three months. These quarterly plans were quickly outdated by new information about residents' familial situation, behavioral changes at the center and school, and recent treatment successes and failures.

The treatment plans met state licensing standards, but they did not play the important role of coordinating departmental treatment planning with other departments, which, of course, were their primary purpose. Daily treatment decisions did not reflect the stated goals and treatment modalities in the treatment plans.

To counter this problem, each department (clinical, paraprofessional, and school) developed its own plan. The result was three distinct treatment plans that reflected the specific goals of each department. The school had a treatment plan based on the Individual Educational Plan, the IEP. The paraprofessional treatment teams had milieu treatment plans, and the clinicians had clinical treatment plans for each resident.

The idea was to make each of these plans reflect the specific treatment strategies of each department. With the focus of each plan narrowed to departmental strategies, treatment goals would be more timely and relevant. This helped in focusing treatment strategy within each department, but it added to the isolation between departments. There was minimal coordination or commonality between the three plans, and often the goals of one departmental plan conflicted with the goals of other departmental plans.

Briefly stated, the problem addressed by the practicum was staff frustration regarding treatment planning and cross-purpose implementation of treatment decisions. The child care workers were excluded from the formal treatment planning process, and the treatment plans did not reflect current, interdepartmental treatment strategies.

Problem Documentation

1. The frustration of the paraprofessional child care workers was evident through examination of exit interview questionnaires and interviews with child care workers at the center. Upon resignation, all staff members are requested to complete a questionnaire that specifically asks the employees to comment on the program, supervision, administrative support, and general feelings about the employment experience. The resigning employees are also asked to evaluate critically and comment on any policy or

procedure, based on their experiences at the center, that needed improvement. This questionnaire is used as a focus of discussion in the final exit interview with the center's director.

During the last 6 months, three paraprofessional child care workers resigned and completed the questionnaire before leaving. Although the three employees wrote that they liked working with the residents at the agency and generally felt that their employment experience was beneficial to their personal growth, all three reported significant frustration in not being part of the treatment planning process.

In reviewing the three exit interview questionnaires, the writer discovered three common and significant reasons for paraprofessional dissatisfaction with employment at the center: (1) the counseling team supervisors did not regularly inform the child care workers about treatment decisions regarding residents on the child care workers' caseloads; (2) because the paraprofessional staff lacked input into the formal treatment planning, it was nearly impossible to understand what was being accomplished by the clinicians in individual therapy sessions; and (3) the milieu treatment plans did not reflect child care worker opinions and ideas.

Another significant evidence that documented paraprofessional staff frustration was the number of in-house incident reports written by the child care workers. During January, February, and March, 1991, the writer recorded all in-house incident reports written by the 11 paraprofessional caseload counselors complaining of lack of respect toward them from residents. An average of 13 incident reports per month were recorded and filed. A common theme in the incident reports was that resident disrespect was primarily due to the paraprofessional workers' lack of authority in making long-term treatment decisions. Five of the 13 incident reports expressed the level of caseload counselors' frustration by asking when the supervisor was going to do something about the residents' behavior. Residents would simply shrug off the caseload counselors, knowing that the counseling team supervisor was the real power on the team. The caseload counselors felt helpless and ineffective.

During the 3rd week in February, 1991, the writer questioned 5 of the 11 paraprofessional caseload counselors about how often they were asked by supervisors for input of specific treatment goals for residents assigned to their caseloads. Only two caseload counselors reported having regular input to the supervisors before the quarterly treatment planning session. One caseload counselor reported that the supervisor required caseload counselors to submit their versions of the quarterly treatment plan before the treatment planning session. However, three caseload counselors rarely were asked about important treatment goals that should be part of the revised plan. Of these five caseload counselors, not one had seen the separate clinical plans developed by the professional clinical staff, and two caseload counselors did not know the clinical plans existed.

2. The second discrepancy addressed was the lack of communication between staff of different departments at the center. Clinicians complained that decisions are made by supervisors to terminate the placement of dysfunctional residents without first consulting them. Clinicians reported that many supervisor and caseload counselor decisions were contrary to the treatment goals they have developed. The director of clinical services wrote a formal memo to the writer expressing frustration in not being informed routinely about decisions made by the team supervisors.

The writer interviewed the four professional staff members (two licensed clinicians and two clinical interns) in March, 1991. One clinician expressed concern about the lack of contact with the paraprofessional supervisors and caseload counselors, stating that it was nearly impossible to coordinate clinical efforts with the behavioral goals of the line workers. The other clinician reported that during the last year there has been improvement in communication with the paraprofessional staff but it took excessive time and energy to accomplish. When asked why it was so difficult to coordinate clinical goals with the paraprofessional staff, the clinician reported that there was no mechanism for regular contact, which resulted in missed opportunities to coordinate strategies and poor communication.

The two clinical interns expressed feelings of inhibition in approaching the counseling team supervisors. They worry about paraprofessional goals contrary to the instructions of their immediate supervisor, the director of clinical services. In fact, all four professional staff members expressed concerns that their loyalty was unnecessarily divided between departmental expectations and the demands, wishes, input, and the expectations of the counseling team supervisors and other paraprofessional child care workers. Usually, this resulted in the clinical staff "doing their own thing" and hoping that it was useful and not conflicting with the total treatment strategy.

The counseling team supervisors were not aware of specific treatment goals or modalities utilized by the clinicians or the educational plans developed at the school. In one documented case, the counseling team supervisor did not know the clinician had regular contact with the mother of a resident who the supervisor was trying to locate. In a recent treatment planning session, a supervisor did not know that two residents were learning disabled, and in both cases proposed that the residents be referred to the public school system without acknowledging the special educational needs. Both instances resulted in verbal reprimands from the director of treatment.

3. Treatment plans did not reflect interdepartmental strategies and are quickly outdated. The third discrepancy was documented by a review of current treatment plans on file. The writer randomly selected five resident treatment files and reviewed the five paraprofessional/milieu treatment plans and the five clinical treatment plans in the files. Only residents who have been in the program for a minimum of 3 months were subject to selection. The selection of measurement categories was based upon those items the director of treatment and the clinicians believed were important for a comprehensive treatment plan for both the paraprofessional and clinical departments.

The paraprofessional/milieu treatment plans were prepared by the counseling team supervisors. The plans were reviewed and revised quarterly (see Table 1).

Table 1

Review of the Items That Should Be Present in the Paraprofessional/Milieu Treatment Plans

	Resident File Number				
Items Reviewed	1	2	3	4	5
Case History	Yes	Yes	Yes	Yes	Yes
30 day goals	Yes	No	No	No	No
Interventions	Yes	No	No	No	No
Clinical goals	No	No	No	No	No
Sp. Ed. Class.[a]	No	No	No	No	No
School goals	Yes	Yes	No	No	Yes
Family goals	Yes	Yes	No	Yes	No
Discharge Plan	Yes	Yes	No	No	No
Psychotropic Meds	N/A	No	N/A	N/A	No

Note. [a]Special Education Classification (Learning Disabled/LD, Severely Emotionally Disturbed/SED) for residents qualified for special educational services. Except for resident case histories and Special Education Classification, the measured categories are specific short-term treatment goals (30 days).

N/A is not applicable.

Significant emphasis was placed on case histories and departmental treatment strategies. However, the paraprofessional/milieu plans were quickly outdated. Of the five plans reviewed, only one plan had treatment goals and interventions documented for the current month. The other four plans documented long-term quarterly goals and treatment interventions. The plans did not reflect the specific clinical goals and treatment modalities. Only three of the four plans reviewed had specific school goals documented for the next quarter. Not one of the five plans reviewed had the special education classifications documented. And most disturbing, the paraprofessional/ milieu plans did not record the use and justification of prescribed psychotropic medications.

The writer reviewed five treatment plans prepared by the professional clinicians. The plans are reviewed and revised quarterly (see Table 2).

Table 2

Review of the Items That Should Be Present in the Clinical Treatment Plans

	Resident File Number				
Items Reviewed	1	2	3	4	5
Case History	Yes	Yes	Yes	Yes	Yes
30 day goals	Yes	Yes	No	Yes	No
Interventions	Yes	Yes	No	Yes	No
Milieu goals	Yes	No	No	No	No
Sp. Ed. Class.[a]	No	No	No	No	No
School goals	No	Yes	No	No	Yes
Family goals	Yes	Yes	Yes	Yes	No
Discharge Plan	No	No	No	No	No
Psychotropic Meds	N/A	Yes	N/A	N/A	No

Note. [a]Special Education Classification (Learning Disabled/LD, Severely Emotionally Disturbed/SED) for residents qualified for special educational services. Except for resident case histories and Special Education Classification, the measured categories are specific short-term clinical treatment goals (30 days).

N/A is not applicable.

The clinical treatment plans did not reflect paraprofessional treatment concerns and goals, and only two clinical treatment plans had specific educational goals documented. Not one clinical treatment plan had specific references to special education classification. Discharge planning was missing from the five plans, and only one clinical plan had observational notes and justification for the use of prescribed psychotropic medication.

Causative Analysis

Assuming the employees at the center have a vested interest in providing appropriate services to the residents, and that employees desire a sense of contributing to the success of the program, the problem was not caused by a lack of commitment. With limited resources, salary and benefits could be a primary cause of frustration among staff members. No member of the center's staff is paid an equivalent salary to state and county employees doing similar work. The medical benefit package is comparable with the public sector, but there are fewer paid holidays and vacation time offered at the center than what an employee would receive working for the state or county. Yet, the center does not have difficulty in attracting qualified applicants.

The reason employees choose to work in the under-funded private sector is the chance to make a difference.

The center offers a unique opportunity to work one-on-one with residents. Employees are encouraged to be inventive and self-reliant. They are part of a team that values individual effort and input. They do not have to deal with the large bureaucratic systems bloating the inefficient public sector. A small, private, non-profit organization offers employees direct access to the top administrative staff not possible in the bureaucratic public sector. The problem was not personality or employment policy, but the administrative and treatment structure that isolated staff members by departments, thus, inhibiting communication and effective coordination of treatment strategies.

1. The paraprofessional child care workers were frustrated because they had limited input in the formal treatment planning process. Therefore, they had little investment in appropriate interactions with residents that reflected consideration of the formal, specific, individualized treatment goals development by the counseling team supervisors, clinicians, and teachers at the school.

The child care workers are the primary providers of care at the center. They have the frustrating task of providing basic services and supervision for the residents. They work the evening and night shifts. They work the weekends and holidays when administrative, supervisory, and professional staff are not around. The child care workers must attend daily group sessions with the residents, hear the same monotonous feedback and excuses, deal with the same frustrating, routine behavioral problems, and attempt to process these issues at a therapeutic level. They work for months shaping resident behavior and providing basic care in the simple hope of successfully graduating the residents on their caseloads from the program. The only thanks the child care workers get is the occasional piece of cake and testimonies when a resident graduates. And after this hard-fought success, celebration and cake, the intake social worker presents them with a new resident with all the dysfunctional behaviors that they worked so hard to modify in the resident who just graduated.

The child care workers were relegated to the level of the paraprofessional--a label the writer refuses to use at the center. It is an accurate description of staff members who do not have advanced degrees and licenses. Yet, it is a pejorative label, often characterizing the child care workers as people not qualified to make major, professional treatment decisions. Child care workers may be intelligent and experienced. They certainly have a relevant perspective about the daily progress and behavioral problems of residents. Yet, because they do not have an advanced degree, they are not "professionals."

The basic philosophy of the center is that the child care workers are professionals, and their daily experience and perspective about the residents are invaluable. The center places the child care workers in the center of the group model. Yet, because the child care workers were excluded from the formal treatment planning process, their input was not validated at the same level as input from administrators, professional clinicians, and supervisors. This was a major contradiction and the major reason for child care worker frustration. The child care workers perceived treatment planning at a professional level, and because they were excluded from the process, they concluded that their services were not professional but relegated to the paraprofessional, non-advanced degree levels of line work.

All staff members, professional and paraprofessionals, have been verbally abused by residents. Because the child care workers have the most contact with resident and are the largest number of staff at the center, it is not surprising that they receive the most abuse and disrespect from dysfunctional residents. The child care workers have the immediate means to deal with dysfunctional behavior. They can convene a group at any time and at their discretion. They have the power of the vote, and they can impose group sanctions on any member of that group. They determine if a resident is entitled to a home pass, can go on activities, or stay up late on weekend nights to watch television or play in the recreation room. With all this power at their disposable, the frustration the child care workers felt was not due to the lack authority to control residents. Their exclusion from the ranks of professional decision-making was, in itself, the primary reason from their frustration.

2. To consider the underlying causes for the second discrepancy, it is necessary to understand the reason for the present administrative structure. The center's treatment philosophy emphasizes the full participation of the paraprofessional line workers. The child care workers have the most contact with resident and, therefore, a unique perspective on behavior and progress in the program.

The group model was developed in a time of limited resources when a single child care worker was responsible for supervising as many as twenty residents. Utilizing the child care workers as the primary care providers allowed the center to develop a successful program. Also, the emphasis on the role of the paraprofessional was a reaction against the traditional medical/social worker model that placed emphasis on the clinician/social worker making major treatment decisions and relegated the paraprofessional workers to behavioral management.

In the past, the center exclusively provided services to adolescent boys who were on probation. The threat of termination from the program and return to the county camp and juvenile detention system was enough incentive to allow paraprofessionals to handle the most seriously delinquent adolescents in an open-community based residential center. During the last 5 years, the population at the center has shifted from a total population of delinquent adolescent boys to a mixed population of court dependents (abused/neglected boys) and probation referrals with minor offenses (stealing, running away from home, truancy, etc.). With the addition of licensed clinicians to the staff, the center had to adjust to a new level therapeutic intervention and interdepartmental cooperation.

The program emphasis remained highly protective of the role and authority of the child care workers. Yet, in developing the new model combining professional and paraprofessional services, an over-reaction occurred. To maintain the primary role of the paraprofessional in providing treatment services, the center did not include the new clinical role into the group process but chose to isolate it as an ancillary service. Departmentalization of services did not allow for effective communication between professional and paraprofessional staff members.

The frustration of poor communication and cross-purpose planning was exacerbated with the addition of the school. Counseling team supervisors spent too much time gathering information from the school and the clinicians. This was the primary reason counseling team supervisors were not aware of specific details such as the IEP process at the school or the issues being discussed in clinical sessions. The departmentalized structure complicated the coordination of services, isolated staff members by departments, and made effective treatment strategy difficult.

Briefly stated, communication between departments was ineffective because treatment planning was divided by departments, resulting in three different treatment plans. The result was cross-purpose planning and poorly coordinated implementation of treatment services.

3. Treatment planning was a weekly event at the center. The three treatment teams rotated, and four residents from a single team were reviewed each week. The meeting was attended by center's director, the psychiatrist, the psychologist, the school social worker, the counseling team supervisor, and the clinician assigned to the residents being reviewed. The schedule permitted each resident's case to be review once every three months.

From the information presented by representatives from the three departments, three revised plans (milieu, clinical, and educational) were prepared by the individual departments. The quarterly review format did not allow for more frequent review of resident treatment goals. Important information regarding treatment successes and changes in strategy were not recorded in a timely manner. Within a few weeks the quarterly plans were outdated and rarely utilized. Daily interactions between staff and residents did not reflect current treatment goals. Again, departmental treatment planning does not maximize a coordinated effort of all staff members providing services.

The administrative structure and the rotating team schedule prevented each treatment team from meeting weekly. The exclusion of the child care workers from the formal treatment planning process limited the number of resident cases reviewed each week. Also, the separate departmental plans were ineffective and added to staff frustration and ineffective treatment planning. With each department having separate treatment plans, cross-purpose planning, staff confusion, and a lack of coordinated treatment strategies was difficult to overcome.

Relationship of the Problem to the Literature

The seriousness of emotional disturbance among children and youths in residential care has increased during the last 2 decades because of the significant decrease in the number available psychiatric beds. This increased has had severe effects on the services provided in mental health and residential care (Gable & Strain, 1979; Weintrob, 1974; Zimmerman, 1990). With the increase of emotionally disturbed, multiply-diagnosed children and youths in group home facilities that previously treated delinquent and abused/neglected populations, residential programs have had to modify their treatment strategies.

The problem facing residential treatment in the private sector is not the lack of sufficient staff numbers to do the job, but the misuse of staff time and the divisions faced by staff due to inhibiting administrative structures (Vorrath & Brendtro, 1985). Thoughtful planning and coordination of the present level of staff can provide adequate and efficient treatment strategy. Perceptive residents can manipulate an inconsistent and dysfunctional staff. Residents can disrupt the best treatment strategy despite the merits of the treatment goals if they perceive staff members in conflict with each other (Garner, 1988).

1. The use of paraprofessionals in mental health began in the 1950s and 1960s because of the shortage of professionals (licensed therapists/social workers) in human services (McGee & Pope, 1975). Paraprofessionals are part of the mental health system. They have most of the direct contact with clients. In an agency with directors, supervisors, and professional clinicians at the top of the

power structure, a reaction from the paraprofessional ranks is to be expected. Often, this reaction has negative effects on the implementation of treatment strategies (Vorrath & Brendtro, 1985).

Krueger (1990) described his experience as a new child care worker at a facility for troubled youths. The weekly 2 hour treatment planning session was attended by all staff members, and all residents were subject to discussion during the meeting. Because of the number of staff attending the meeting and the sheer number of residents subject for possible review, little preparation was involved, particularly by the child care workers. By default, the facility's psychiatrist took up the mantle to gain focus and lead the discussion. The child care workers' role was relegated, more or less, to a learning and listening posture while the psychiatrist spoke about things far beyond the expertise of many staff members attending. The psychiatrist had limited contact with the residents, usually no more than two or three individual sessions per resident in 6 months. The psychiatrist described behavioral issues in terms of the underlying psychological/psychiatric dynamics, and prescribed treatment goals and intervention techniques that had little to do with the daily experiences of the child care workers. The focus of the meeting did not help Krueger or his peers understand resident behavior or how to "therapeutically" intervene. This added to their frustration. The treatment decisions and plans were quickly forgotten by the line staff.

Munson, Klein, and Dalafield (1989) reported that most facilities treating adolescents have developed a dichotomy between the professional and paraprofessional staff. The professional staff are dynamically oriented, whereas the paraprofessional staff addresses the same youths with a behavioral approach. The medical/social worker model has been transferred from the mental health facilities to the group home, a model that separates the roles of the professional/clinical staff from the paraprofessional staff who must maintain the living unit's milieu. Thus, treatment at most residential facilities is divided along the professional/paraprofessional line--those who have advanced degree and licenses, and those who do not have advanced degrees and licenses.

Confusion develops when professionals making treatment decisions do not adequately provide for the needs of the paraprofessional. In the medical/social worker model, psychiatry remains the primary provider of therapeutic treatment, and all other services are relegated to the ancillary level. Thus, most residential facilities have promoted the concept of no therapeutic interventions between professional clinical sessions. The paraprofessional child care workers are not providers of professional therapy, resulting in resentment and cross-purpose intervention between the divided professional and paraprofessional departments (Vorrath & Brendtro, 1985).

The assumption that the professional clinicians have a priority role in making treatment decisions is not supported by the amount of contact between professionals and residents. The result is an "ivory tower" environment, in which clinicians design treatment strategies to meet their expertise, not necessarily the specific needs of the clients while in the living unit or the child care workers who must work within the restrictive environment of providing total care without the authority to make crucial treatment decisions (Vorrath & Brendtro, 1985).

Szasz (1973) refuted the professional's claim to a superior decision making position over the paraprofessional. By position, the psychiatrist, according to Szasz, becomes the patients advocate, whether or not the advocacy is for the benefit of the patient. The lack of restraint by the psychiatrist and other professional providers leads to possible tyrannical abuse of patients rights. The psychiatrist is often the patient's oppressor.

Despite the lack of advanced degrees and licenses, the paraprofessionals have a unique understanding of the treatment needs of the residents under their care. Child care workers become frustrated when they have little input into important treatment decisions that potentially affects not only the residents' behavior but the paraprofessionals' role. They are further frustrated in their attempts to deal with dysfunctional children and youths when they perceive professional decisions as contrary to their needs and interfering with their jobs (Adler, 1976).

2. Liverpool (1990) studied the use of participatory management at three manufacturing plants in the Midwest. The research revealed that participation by line workers in participatory decision making did not produce significant increases in productivity unless the workers were allowed to make decisions beyond the shop floor. Increased cooperation from child care workers cannot be expected if their decision-making authority is limited to decisions affecting only the living unit.

Troubled children have a perception of themselves that produces a negative response to their behavior from others, what Krueger (1983) called the "circular effect." When a youth enters a treatment facility, cooperation between staff members is important if treatment is going to be effective and staff efforts are going to reverse the negative effects of the resident's behavior. Coordination of staff efforts must be the priority. If there is a lack of coordination or poor communication between staff members, especially between staff members in different departments offering different services, effective treatment is nearly impossible, and at best, it is impeded by excessive staff energy and time wasted on trying to coordinate services between departments.

In human services, a division between service providers has occurred. This division is usually drawn according to expertise (Briggs, 1973), and departmentalized staff members are usually invested in maintaining the status quo. The advancement of new ideas and staff cooperation to potential change are subject to the negative effects of departmental biases and preservations. As long as staff members are divided according to expertise and have a vested interest in maintaining those divisions, residents' needs will always take a back seat to departmental, territorial resistance and strife. The professional can destroy the efforts of the paraprofessional worker. Coordinated staff effort is weakened by the professional's insistence that individual psychotherapy prevail over all other forms of intervention. Because of this bias, excuses are made by professional clinicians for a resident's dysfunctional behavior in the name of therapy. The client is in the middle of this struggle--a fight to maintain territorial boundaries and exert departmental strategies without regard to the work of other staff members. A divided staff is easily controlled by a dysfunctional and disturbed population (Garner, 1988).

The primary goal of any organization management style/structure is to produce and market its products effectively. Tannenbaum and Schmidt (1958) researched leadership patterns attempting to resolve the problem of how much subordinate decision making could be allowed with management maintaining necessary authority. Combining the ideas of group dynamics within organizational structures, Tannenbaum and Schmidt devised a "Continuum of Leadership Behavior." The continuum ranged from autocratic management style, in which management makes decisions and announces the decisions to employees, to a system in which management allows the group of employees to make decisions within specific guidelines. A management style/structure that autocratically enforces change upon employees is more likely to raise the level of employee resistance to change, deny employees incentive and motivation to make changes, and deprive the employees of a role in changes that affect their jobs, thus, lowering productivity. The management-center leadership style/structure is prone to an autocratic, management authority pattern over the decision-making process for the entire organization. The area of freedom for subordinates is strictly regulated by the amount subordinate-centered decision making allowed within the organization.

Demchak (1987) reported that staff effectiveness in managing student behavior in the special education classroom setting is dependent upon the organizational structure that either facilitates or impedes staff participation at every level. Treatment centers fail to provide effective services when the paraprofessional child care workers lack authority to make treatment decisions the same way classrooms fail to provide appropriate remedial education when teachers lack the authority to make basic decisions that affect their classrooms.

Block, Boczkowski, Hansen, and Vanderbeck (1987) studied treatment planning at a skilled nursing facility for the elderly. The authors reported that poor treatment coordination led to poor communication and cross-purpose treatment goals. This frustrated staff at every level of expertise and job description, resulting in less than optimal care for the patients.

Staff frustration is multiplied when the hierarchal structure places the professional staff member at the top of the hierarchy. In such structures, the professionals are separated not only by superior position over the paraprofessional, but are often solely responsible for the formal treatment planning process, thus further isolating the paraprofessional. The result is confusion and frustration among staff in all departments. The anger experienced by a divided staff perpetuators poor communication and cooperation. Staff members become involved in efforts to support their departmental goals, often conflicting with goals of different departments (Garner, 1988; Krueger, 1984, 1990; Ryback, 1974; Vorrath & Brendtro, 1985).

3. In residential treatment facilities, treatment plans must reflect not only the individual staff member's effort but the total treatment strategy of all staff members involved with the residents. A hierarchical treatment structure with the professional making most of the critical treatment decision emphasizes specific treatment strategies known only by the professional and neglects the input and experience of other members of the treatment team. Treatment plans reflect this professional bias (Garner, 1988, Ryback, 1974).

Often, too many therapeutic approaches for a wide range of behavioral objectives are formalized on a treatment plan in an attempted to provide total treatment. Without interdepartmental treatment focus, staff at different departmental levels may attempt to provide the widest range of services. Vorrath and Brendtro (1985, pp. 126-127) described this antiquated departmentalized planning as the "cafeteria approach" to treatment planning. As a result, all modalities are adulterated in an inefficient attempt to provide too many varied services by too many departmentalized staff members. A common error made is wanting specific treatment interventions to work, not whether the interventions are appropriate (Schowalter & Fisher, 1982).

A divided staff departmentalizes treatment planning. The departmental model does not efficiently blend the experience and ideas of all the staff members who have regular contact with the clients. A total treatment strategy that includes the input of all staff members providing services is missing. Under the departmental structure, staff from one department is likely to find out things in the program from clients and not through interdepartmental communication (Garner, 1988). Important client information may be overlooked or misunderstood if it is not made available to all staff members who provide services. The person making treatment decisions may not be aware of what other staff members are doing. This person may not be as qualified or as adept in making these decisions as someone in another department (English & Mortenson, 1981a). Team leadership and interdepartmental coordination may not be a strong point or the emphasis of a departmentalized supervisor or clinician. The result is a limited focused treatment plan.

The lack of efficient treatment coordination is often caused by staff scheduling that does not allow for members of different departments to meet at one time (Krueger, 1984). When teams do meet, they often fail to prioritize the most important treatment questions, client information, and staff responses to devise a coordinated strategy. Staff may try to resolve issues that are unrelated to the most critical treatment issues. Staff may attempt to devise a treatment strategy for which there is no expertise among team members to fulfill the treatment goals. Departmental cliques may prevent staff from compromising treatment goals (Grady & Wilson, 1981).

A total treatment strategy cannot emerge if staff members are isolated from the treatment decision-making process. Failure to allow input from all levels of staff makes effective treatment planning nearly impossible. The result is staff frustration, cross-purpose treatment strategies, and ineffective treatment plans.

The literature review came from various domains: residential treatment for children and youths (Adler, 1976; Gable, et al., 1979; Garner, 1988; Krueger, 1983, 1984, 1990; Vorrath & Brendtro, 1985; Weintrob, 1974; Zimmerman, 1990); nursing facilities for elderly patients (Block et al., 1987); social work and mental health (Briggs, 1973;

McGee & Pope, 1975; Schowalter & Fisher, 1982; Szasz, 1973; Tavorone, 1988); special education (Demchak, 1987); hospice care for the terminally ill (English & Mortenson, 1981a; Grady & Wilson, 1981); and business and manufacturing (Liverpool, 1990; Tannenbaum & Schmidt, 1958).

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Based on the discrepancies reported in Chapter II, the following goals and expected outcomes were projected for this practicum:

Goals

1. The paraprofessional child care workers will be less frustrated. They will have more investment in the implementation of specific treatment objectives. They will experience a higher level of job satisfaction and less frustration because their ideas will be appreciated at the same professional level as the clinicians, supervisors, and teachers.
2. There will be improved cooperation and communication between administrators, educators, professional clinicians, and the paraprofessional counseling team supervisors and child care workers. Treatment planning will be coordinated between departments. Counseling team supervisors will be informed of decisions and treatment goals of the clinicians and teachers. Clinicians will be aware of the treatment decisions made by the paraprofessional staff. And teachers

will be aware of residential treatment objectives.

3. Treatment plans will be coordinated between departments and reflect interdepartmental objectives. Individual treatment plans will be reviewed and revised monthly. Recent therapeutic successes and setbacks, and resident behavioral changes and goals will be incorporated into the treatment plans reflecting a current strategy and resulting in a more formal, but practical instrument that will be useful to staff members in every department.

Expected Outcomes

Through implementation of the practicum, improved coordinated treatment planning will be the primary result. Implementation will be interpreted as successful when staff members from every department are part of the treatment planning process and treatment objectives are effectively coordinated between departments.

1. The paraprofessional child care workers will be active participants in the treatment planning sessions. With their inclusion into the treatment planning process, the child care workers should feel less frustrated. They should see their roles as part of a therapeutic team, not relegated to behavioral management alone. Their opinions will be appreciated by directors, supervisors, and clinicians. They will have more investment in the implementation of specific treatment objectives. They will

experience a higher level of job satisfaction and less frustration because their ideas will be incorporated in the formal treatment plans.

When included in the treatment planning process, the child care workers will have a vested interest in not only providing basic care for the residents at the center, but they will be aware of the formal treatment strategy for each resident on their caseloads and adapt their interactions with residents in keeping with the specific goals as stated on the treatment plans. They will not feel isolated from a professional level of therapeutic interventions. They will be professionals with a professional's voice in all treatment decisions for the residents on their caseload.

After the implementation phase, the writer will interview the 11 child care workers who have specific duties as caseload counselors. The six interview questions will be as follows:

(1) How often was paraprofessional caseload counselor consulted by supervisors regarding residents on their caseloads?

(2) Since implementation of the practicum, how regular was the caseload counselor worker participation in the treatment planning sessions?

(3) Was the caseload counselor's experience with the

residents in the living unit and ideas about appropriate treatment goals and interventions equal to the input from other members of the treatment team (supervisors, clinicians)?

(4) Has the caseload counselor's position at the center been enhanced by the practicum implementation? If yes, how? If no, what suggestions do they have to improve their participation in the treatment planning sessions?

(5) Since implementation of the practicum, has the caseload counselor experienced less frustration?

(6) Since implementation of the practicum, do treatment plans reflect caseload counselor goals?

The first expected outcome will be successful if upon completion of the implementation phase of the practicum the 11 caseload counselors respond to the interview questions as follows:

(1) Eight out of the 11 caseload counselors workers answer they were consulted weekly by the supervisors regarding treatment decision for residents on their caseloads.

(2) Eight of the 11 caseload counselors answer they participated in every treatment planning session when the treatment plans for residents on their

caseloads were reviewed during the implementation phase.

(3) Eight of the 11 caseload counselors answer their input was equal to that of other staff members (professional, teachers, supervisors) in the treatment planning sessions.

(4) Eight of the 11 caseload counselors experience a positive change in their roles (from paraprofessional behavioral managers to equal members of a professional treatment team).

(5) Eight of the 11 caseload counselors experience less frustration in performing their duties.

(6) Eight out of 11 child caseload counselors report that their concerns and treatment goals are included on the treatment plans.

If the first expected outcome is realized, the caseload counselors will have an improved knowledge of the treatment goals of the other departments. If the caseload counselors are aware of clinical goals and educational objectives, they will coordinate their efforts with the professional staff and educators, and this will be a significant achievement.

The caseload counselors will be seen by residents as having the authority to change and implement treatment decisions. As a result, there should be more cooperation and less verbal abuse by residents toward the caseload counselors. The writer will measure this outcome by surveying incident reports during the three month implementation period. This expected outcome will be determined successful if the average number of incident reports dealing with resident disrespect and verbal abuse is lowered from the monthly average of 13 reports during January, February, and March, 1991 to an average of 7 reports per month during the three month practicum implementation phase.

2. The second expected outcome of the practicum will be improved coordination between members of different departments in the development and implementation treatment strategy, resulting in less cross-purpose planning. The clinicians will have active participation in full treatment planning, including the behavioral goals of residents. The supervisors will be aware of specific goals of the clinical and school staff. Teachers will know the specific behavioral goals of residents at the center.

After the implementation phase, the writer will interview the professional staff (the director of clinical services, the clinicians, and the clinical intern), the three counseling team supervisors, and the four teachers at the center's non-public school to determine if cooperation between the three departments has improved since the implementation of the practicum. The interview questions will be as follows:

(1) How often do staff from the three department consulted each other regarding specific treatment decisions?

(2) Since implementation of the practicum, how has the positions in each department improved?

(3) Has their professional relationship with the caseload counselors improved?

(4) Since implementation of the practicum, has there been an improvement in the coordination of clinical, paraprofessional, and the school treatment objectives?

(5) Do the treatment plans reflect crucial interdisciplinary objectives?

The expected outcome will be considered successful if the staff members from the three departments answer the questions as follows:

(1) Nine of the 12 staff members report that they were consulted weekly with staff members of different departments.

(2) Nine of the 12 staff members report that their positions at the center have been enhanced since the practicum implementation--improved communication with other staff members and less

cross-purpose planning.

(3) Nine of the 12 staff members report that their relationship with the caseload counselors has improved.

(4) Nine of the 12 staff members interviewed report that there has been significant improvement in coordinating treatment objectives with other departments.

(5) Nine out of the 12 staff members interviewed report that treatment plans reflect clinical, paraprofessional and educational objectives.

3. The third expected outcome of the practicum will be improved treatment plans that reflect current information, and interdepartmental strategies. To measure the success of this expected outcome, the writer will randomly select five treatment files and review the paraprofessional/milieu and clinical treatment plans. Implementation of the practicum will be determined successful if the following results are found:

(1) Four of the five paraprofessional/milieu and clinical treatment plans have been reviewed monthly during the implementation phase.

(2) Four of the five paraprofessional/milieu and clinical treatment plans have documented resident case histories.

(3) The number of paraprofessional/milieu treatment plans that document specific 30 day paraprofessional treatment goals increased from one to four.

(4) The number of paraprofessional/milieu treatment plans that document specific treatment interventions, modalities, or referrals for specific 30 day targeted day behavioral goals increased from one to four.

(5) The number of paraprofessional/milieu treatment plans that document specific clinical treatment goals increased from zero to four.

(6) The number of paraprofessional/milieu treatment plans that document resident Special Education Classification, if applicable, increased from zero to four.

(7) The number of paraprofessional/milieu treatment plans that document specific educational/school goals increased from three to four.

(8) The number of paraprofessional/milieu treatment plans that document specific resident family goals or emancipation planning increased from three to four.

(9) The number of paraprofessional/milieu treatment plans that document specific discharge planning

increased from two to four.

(10) The number of clinical treatment plans that document specific 30 day clinical treatment goals increased from three to four.

(11) The number of clinical treatment plans that document specific treatment interventions, modalities, or referrals for specific 30 day clinical treatment goals increased from three to four.

(12) The number of clinical treatment plans that document specific paraprofessional/milieu treatment goals increased from one to four.

(13) The number of clinical treatment plans that document resident Special Education Classification, if applicable, increased from zero to four.

(14) The number of clinical treatment plans that document specific educational/school goals increased from two to four.

(15) The number of clinical treatment plans that document specific resident family goals or emancipation planning remained at four.

(16) The number of clinical treatment plans that document specific discharge planning increased from zero to four.

(17) The justification and use of psychotropic medication was documented on every treatment plan (both the paraprofessional and clinical plans) for residents prescribed these medications.[1]

Measurement of Outcomes

Upon completion of the implementation phase of the practicum, the writer will interview each staff member as outlined above. The interviews will be private and oral, allowing staff members to comment on each interview question. Several questions will be open-ended. The interviews will last for approximately 30 minutes with an opportunity for each staff member to make additional comments regarding the practicum implementation that were not covered by the interview questions. Staff responses and additional comments will be recorded by the writer.

Upon completion of the interview process, the recorded responses will be categorized and analyzed according to the specific expected outcome, and the responses will be documented in the final report. The goal will be to detail the different responses to particular questions in the final practicum report.

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[1] The expectation that every treatment plan properly document the justification and use of psychotropic medications is not unrealistic. The use of psychotropic medications in residential treatment centers is a controversial issue. The center's psychiatrist is required to have court approval before prescribing of any psychotropic drug. The center is required to document daily observations of residents using psychotropic medications in the residents' medical charts. Since daily observation and documentation of possible side effects are already in effect at the center, it is not unreasonable to require proper documentation on the treatment plans.

During the 12 week implementation phase, the writer will review monthly the in-house incident report log. The writer will record the numbers of incident reports regarding resident verbal abuse toward the 11 caseload counselors and provide this information in the practicum report to determine if the solution to the expected outcome was successful.

At the end of the implementation phase, the writer will randomly select and review the treatment plans of five resident treatment files. Only those treatment files of residents who have been in the program during the entire 12 week implementation phase will be subject to selection. The data collected from the review will be analyzed to determine if the solution to the expected outcome was successful.

CHAPTER IV

SOLUTION STRATEGY

The problem addressed by the practicum was the lack of coordination of treatment strategies between staff members of different departments at the project site. The paraprofessional child care workers were frustrated because they did not participate in the formal treatment planning process. A coordinated treatment strategy between departments (paraprofessional, professional, and school) was lacking. Treatment plans did not reflect a coordinated interdepartmental strategy, were quickly outdated, and did not provide consistent treatment goals and prescribed interventions.

Discussion and Evaluation of Solutions

The number of disturbed, multiply-diagnosed children and youths in need of residential treatment has increased during the last two decades. The use of a multi-disciplined approach to treat these children and youths has increased the ability of residential treatment centers to provide appropriate care. Program shifts have occurred from the medical/social worker model to programs mixing the professional therapeutic session with education, vocational, behavioral goals, and the effective use of group dynamics (Weintrob, 1974).

Treatment must be based on a fundamental commitment to effective care of the clients. When staff work together effectively, the result is support for the clients as well as the staff, shared knowledged and empathy between staff members, improved staff accountability, and positive leadership that supports treatment efforts (Krueger, 1983, 1990). Management decisions must consider the opinions and needs of all employees. Only when the organizational structure allows for all staff members to participate in the decision-making process can management effectively motivate staff to suspend departmental/role biases in favor of a total, holistic treatment program (English & Mortenson, 1983b; Tannenbaum & Schmidt, 1958).

Tavorone (1988) described the introduction of participatory management in traditional, hierarchical residential treatment center for the developmentally disabled. Decision making developed through a non-hierarchical process involving all levels of staff in brainstorming and consensus. Participants were involved in the initial planning stage as well as in the direct delivery of services. The new design achieved its desired results because staff members were invested in the new ideas and program design because they were part of the change process.

Participatory management works because the staff functions as a team. Teamwork benefits the organization because members learn to share and communication with each other. More effective services are provided in the coordinated effort than when individual staff members pursue private strategies and personal agendas. Team membership can reduce the isolation felt by staff members separated by a hierarchical structure that promotes departmentalization (Toseland, Palmer-Ganeles, & Chapman, 1986).

1. Paraprofessional child care workers have the frustrating task of providing basic care for children and youths in residential treatment centers. In many treatment facilities the child care workers are relegated to behavioral management of the clients. Rarely are the child care workers the sole providers of care. They are part of group of workers who provide different services. Paraprofessional intervention can offer clients basic care and acceptance, and break the circular effects of resident dysfunctional behaviors (Krueger, 1983). Because the child care workers interact with residents daily and have a wider understanding of their needs, their input into the treatment planning process is vital.

When child care workers are included in the treatment planning process, their productivity and job satisfaction increases. Krueger, Lauerman, Graham, and Powell (1986) cited a survey of 900 paraprofessional child care workers in the United States and Canada. Eighty-five percent of the participants reported that they were employed by agencies using a team approach. The survey reported that individuals' levels of commitment to work were based on the amount of involvement in the decision-making process. Krueger (1984) cited another national survey reporting that 86% of the child care workers in the United States participated in a team model. Again, job satisfaction among the paraprofessional child care workers was linked directly to involvement in the treatment planning process.

The amount of involvement of the paraprofessional in the delivery of services at residential centers varies. Paraprofessional involvement is controversial. Marler (1971) reported that the quality of care decreases in direct relationship to the increase of paraprofessional involvement. Yet, Block et al. (1987), when studying the effects of the paraprofessional's role in a nursing facility for the elderly, reported the paraprofessional's familiarity with the patients improved the quality of treatment strategy. The paraprofessional's direct involvement made implementation of treatment plans more effective. The results of the behavioral program using the nursing aides indicated that the aides grasped the basic principles of the behavioral modality. The nursing aides were competent in not only implementing the model but in designing specific treatment strategies for individual patients. Munson et al. (1989) studied child care workers at a residential treatment center for emotionally disturbed, maladjusted girls. Their research concluded that the paraprofessional child care workers were a valuable asset to the total treatment strategy.

2. The emergence of the paraprofessional in the mental health field has promoted the shift from a therapist-centered approach to a holistic team approach (Krueger, 1990). The interdisciplinary team approach has been federally mandated for remedial special education qualification (P.L. 94-142), the IEP process.

The primary responsibility of residential administration is to supervise and train paraprofessional and professional staff to improve communication, thus improving the capabilities of the facility to provide the widest range of treatment interventions. The team approach provides for the widest range of staff perspective--professional, educational, paraprofessional--and focuses the attention of staff members to a coordinated treatment strategy (English & Mortenson, 1981b; Toseland et al., 1986).

English and Mortenson (1981a, p.4) reported significant advantages to the team model when applied to hospice care for the terminally ill:

(1) Improvement in management team cohesiveness
(2) Improvement in patient care team cohesiveness and communication for improved task completion
(3) Greater acceptance of non-health care providers as full team members, that is, the patient, family, and lay volunteers, with resulting increased appropriateness of care
(4) Improvement in the availability of care through the development of interchangeability of team members, each of whom operates under the same principles of care and knows each patient and family's special problem and preferences
(5) Reduction in staff stress and staff turnover through the provision of meaningful support to individual staff members by the more cohesive team
(6) Improved efficiency and effectiveness within the hospice through improved communication between teams, such as between home care and inpatient teams, or between management and patient care teams

The implementation of the interdisciplinary team approach fosters improved cooperation, communication, learning, and staff support not available in the hierarchical medical/social worker model. It allows existing staff to increase therapeutic interventions. It enhances staff strengths and minimizes staff weaknesses (Garner, 1988; Imber, Neidt & Reyes, 1990; Ryback, 1974; Vorrath & Brendtro, 1985). The interdisciplinary treatment team model assists staff in modifying treatment strategies, utilizing the existing staff, improving staff morale and commitment to organizational goals, and promoting staff specialization within a holistic context (English & Mortenson, 1981b; Wilson & Grady, 1981).

The interdisciplinary team approach to treatment planning has been used in various fields of human services. Hermary and Rempel (1990) studied the use of the Individual Programming Team (ITP) at a community based training program for mentally handicapped adults. The Individual Programming Team provided an integrated treatment strategy involving both professionals and paraprofessionals. The results of the study demonstrated that 52% of the parents and 76% of the staff were active participants in the team model, and that 83.3% of the parents and 88.8% of the staff believed that their individual contribution to the team was valued. The main difficulty of the Individual Programming Team was role definition, with 35% of the parents and 47% of the staff responding to the questionnaire stating that their individual roles on the programming team were not clear. The study did not address the impact of the Individual Programming Teams on the clients.

Hochstadt and Harwicke (1985) studied the effectiveness of the interdisciplinary approach at the La Rabida Children's Hospital and Research Center at the University of Chicago. Staff experience at the hospital revealed that the interdisciplinary approach dislodged and reduced fragmentation and duplication of services. Grady and Wilson (1981) applied the team approach to hospice care of terminally ill patients. The hospice patient is in need of more than physical/medical care. The need for critical, individualized treatment mandated the coordinated efforts of many disciplines.

Toseland et al. (1986) reported that 77% percent of the respondents to their study of team functioning at an inpatient psychiatric facility indicated that their team function effectively, and only 5.7% of the respondents felt that the team rarely functioned effectively. The team approach at the psychiatric center benefitted the entire treatment program. Staff cooperation increased, and a coordinated treatment strategy provided services beyond what was available when staff members worked independently. The interdisciplinary team approach provided added support to staff members, and reduced the feeling of isolation.

Findholt and Emmett (1990) studied the use of interdisciplinary team reviews of psychotropic medication prescriptions for the mentally retarded at the Wyoming State Training School. Given the poor history of misuse of psychotropic medications with the mentally retarded, the study demonstrated the team's effort to make the prescribing of these medications part of an interdisciplinary approach, justifiable only when the team believed that the use of medications was a means of last resorts and subject to future team assessment regarding effectiveness. Through the team approach other treatment methods (behavioral modification techniques, environmental considerations, and staff training and supervision) were considered before the prescribing of psychotropic medications.

Harris and Harris (1989) described team management approach in businesses that compete globally with other international firms. Team management allowed employees to fulfill multiple roles while supporting the company's efforts and increasing business production.

Imber et al. (1990) researched factors that were associated team decision making in secondary schools where the teachers were the primary participants in the decision-making process. The study reported that there was a direct link between involvement in participatory decision making and the level of member commitment to the task. Teachers who participate in the decision-making process reported improved self-image and increased influence in the classroom and at the school as a whole.

In residential programs for children and youths, a holistic team approach has been advocated. The inclusion of staff members from the living unit, the professional department, and the school widens the scoop of possible staff interventions (Buchanan & Rogers, 1980). The team approach is people-centered, entrusting therapeutic interventions for the total care of the clients to the people who have contact with the patients.

After the implementation of the interdisciplinary team approach in a residential center for youths, Krueger (1990) reported that the new system provided staff with a sense of control and autonomy over the children. The staff felt more valued by the administration, and the work load of the child care workers became manageable.

Garner (1982, 1988) offered the concept of the Total Team Model. The child care workers, social workers, teachers, and administrators participate in a regularly scheduled meeting designed to provide for the total treatment needs of the residents. Decisions are obtained by a majority vote. The Generic Team Approach (Krueger, 1983, 1990) takes the concept of interdisciplinary team one step further by proposing that every member of the team (the paraprofessional as well as the professional) is totally equal with comparable salaries and benefits. According to Krueger, for the team to obtain consensus, individual members of the team must be willing to compromise. Every aspect of care (treatment planning, home passes, discharge planning, etc.) is subject to team discussion and decision. No decision regarding the care of residents is sacred. Vorrath and Brendtro (1985) offer the concept of Team Primacy. Like the Total Team Model and the Generic Team Approach, all treatment decisions are subject to full discussion by all members of the treatment team, especially the paraprofessional child care workers who have a unique perspective on the needs of the clients.

Communication between staff members of different disciplines improves through the interdisciplinary nature of the treatment team model. Effective treatment planning is accomplished through a group format that allows each member of the team to express feelings and ideas without fear of judgment or automatic rejection due to position within the organization. Departmental specialization does not take precedence over team consensus (Ryback, 1974; Vorrath & Brendtro, 1985).

Staff accountability improves through the group process. Team members take responsibility for not only their own perspective and treatment strategies, but for the perspective and ideas of other team members. Team members hold each other accountable. They monitor their own progress the same way they monitor client progress (Krueger, 1990; Vorrath & Brendtro, 1985).

3. The interdisciplinary team approach provides a format for the review and revising of treatment plans. Formal treatment planning has become a necessity in residential

programs. Not only are individual psychodynamic, behavioral, and pharmaceutical therapies part of treatment, consideration must be given to education, vocational goals, family involvement, recreation, and the daily needs of the child care workers who are charged with caring for the clients in the living unit. Coordinated interdepartmental treatment strategies that include paraprofessional input must be reflected in a treatment plan. The plan must weave the goals and interventions of staff members who have regular contact with the clients (Krueger, 1990; Smith, 1986; Vorrath & Brendtro, 1985; Weintrob, 1975).

Treatment planning must define not only the treatment strategy of individual staff members, but the operational plans for the entire treatment program. Treatment is more than the therapeutic hour. Treatment goals should be stated in terms at the paraprofessional's understanding (Ryback, 1974). The sharing of information from different staff perspectives gives a complete picture of the needs of clients and the appropriate interventions to be employed.

Formal treatment planning becomes the priority in residential treatment. The interdisciplinary treatment conference brings together the information regarding all dynamics of the clients. It allows staff members from different departments to interact, share possible solutions, support each other, and determine what treatment interventions are to be employed and what team member or group of team members will provide specific treatment interventions. Specific assignments are not based upon professional status or position alone, but upon who is more appropriately assigned each task (Garner, 1988; Ryback, 1974; Toseland et al., 1986). Through effective interdisciplinary treatment planning, treatment plans reflect the widest range of objectives and allows the formal treatment plan to reflect staff consensual observations, ideas, and interventions possibilities and enhance available resources (Krueger, 1983).

An effective interdisciplinary treatment plan reflects staff members consideration based on observation, then interventions that are properly applied to the case history and staff observation (Krueger, 1983; Schowalter & Fisher, 1982). The treatment plan must be individualized for each client. It begins with an initial screening or assessment of needs. Treatment interventions and assessment of treatment strategy are based on input from all members (Krueger, 1990; Ryback, 1974; Vorrath & Brendtro, 1985). The effective treatment plan places priority on possible client resistances that are likely to impede treatment, and determines specific goals before individual treatment interventions are assigned. The treatment team must have the authority to amend the plan. Plan revisions are evidence of the team's responsiveness to changing needs, not poor initial planning (Schowalter & Fisher, 1982).

The treatment plan must be logical with specific treatment objectives clearly defined and interventions that match the expected outcomes (Ryback, 1974; Krueger 1983). The time reference for each goal and discharge planning is based on consensual treatment observations and planning, not upon an arbitrary program design (Vorrath & Brendtro, 1985). Thus, unified treatment strategy emerges, documented on a formal plan in which every treatment decision and possible therapeutic intervention technique is weighed equally before implementation.

Ideas Generated by the Writer

The project center uses a peer-culture model that advocates the importance of the peer reference group. Much of the group model is based on Tannenbaum and Schmidt's (1958) concept of leader control verses group control. The group model promotes resident participation. All decisions in the group are arrived at by member consensus. The pressure applied by residents against dysfunctional peers is very effective in managing a large group of residents who, as individuals, have learned to terrorize their families and neighborhoods, have committed criminal offenses, and have failed at numerous foster homes and other group homes before placement at the project center.

The level of resident involvement is remarkable. Their inclusion in the decision-making process has bolstered their sense of self-esteem and has allowed them to grow as individuals and as members of a group that can handle the most difficult youths.

In the traditional medical/social worker model, treatment decisions are decided by an elite professional staff who have limited contact with the residents and often do not consider the impact of treatment decisions in the living unit. The child care workers are not in a position to question the professional clinician's decisions. This situation has been partially corrected at the project center.

The difficulty in allowing the child care workers to participate in the formal treatment planning process is definition of role. Because they do not have advanced degrees, are not licensed, and they are not supervisors, their role had to be more fully defined.

Prior to implementation of the practicum, 11 child care workers were assigned to caseloads of three to four residents. They could not compete with the clinical knowledge of the trained licensed clinicians, nor did they have the experience to compete with seasoned supervisors. They could complete in the formal treatment decision-making process as advocates or "parents"--consumers of services provided by the school and the clinicians for the residents on their caseloads. In the same manner that a parent may not question the education and knowledge of a physician or a teacher, they should question the legitimacy of a physician's treatment or the educational goals of the teacher in the classroom. This was where the child care workers could best be of service, by providing advocacy for the residents on their caseloads and demanding that the professionals provide not only needed services but be held accountable for services rendered.

In an attempt to support the paraprofessionals, the center did not choose to include the professional clinicians in the decision-making process, but to isolate them and relegate their treatment goals and interventions to ancillary services. The result was the isolation of important, meaningful therapeutic goals from the living unit. With the addition of the center's non-public school, the program design did not consider the need for the teachers to participate in the treatment decision-making process. The isolation of treatment objectives was strictly divided along departmental lines.

The group model works because it includes the residents in the decision-making process. Treatment coordination would have been more effective if staff members from the three departments were included in the treatment decision-making process. Departmentalization prevented the center from providing optimal care for the residents. Cross-purpose planning frustrated the best intended treatment goals. The group model emphasized consensual decision-making by the residents and the counselors. In like manner, a consensual decision-making format that includes staff members from the three departments (paraprofessional, professional, school) would likely improve treatment strategies. The group model decentralized the decision-making process from a leader orientation to a group consensual orientation. An interdisciplinary treatment team format would decentralize the treatment decision-making process from the ranks of supervisors and professionals to the level of common concern, ideas, and the needs of staff members from every department. The staff reference group would shift from departments to the three treatment teams. Treatment planning would shift from departmental strategies to interdepartmental strategies. The formal treatment process would encompass the common goals of every staff member who had regular contact with the residents. As a result, there should be less isolation and loyalty along departmental lines in favor of consensual, interdisciplinary assessments, goals, and intervention assignments. The professional clinicians would have input into the daily treatment decisions that are currently the private domain of the paraprofessional staff. The paraprofessional child care workers would have a vested interest in following a formal treatment strategy because they will participate in the decision process.

The three departmental treatment plans needed to be consolidated into one interdisciplinary plan that included participation and input from all three departments. This new plan could resemble the Individual Educational Plan (IEP) used by school districts for detailing interdisciplinary goals for students needing special educational services. The consolidated plan should have basic resident demographics, presenting problems and resident history, milieu goals, clinical goals, and education/vocational goals.

Evaluation of Possible Solutions

Implementing an interdisciplinary team approach has potential problems. Toseland et al. (1986) reported that staff often disagree about the level of involvement of particular members of the team. Whereas Vorrath and Brendtro (1985), Krueger (1990), and Garner (1988) advocated equal status for all members of the treatment team, Toseland's study suggested that a totally egalitarian approach may negate the positive contributions of particular expertise, compromising effective professional specialization while satisfying the demands of the total team.

1. Krueger (1990), Garner (1988), and Vorrath and Brendtro (1985) have considered the important contribution of professionally trained and licensed staff, but clearly favor an approach that levels the professional's influence to the equal level of the paraprofessional. The involvement of supported, well-trained and motivated child care workers more than compensates for lack of the advanced degrees. Block et al. (1987) and Munson et al. (1989) have demonstrated the value of paraprofessionals in the treatment planning process. Not only can the paraprofessionals understand treatment modalities, they are in a position to affect the most dynamic changes in client behavior and positive progress.

The idea that paraprofessionals cannot compete with the professional is archaic, and it is not supported by research studies in residential care. Paraprofessional job satisfaction is dependent, in large degree, on participation in a treatment team model (Krueger et al., 1986; Krueger, 1987). Based on the successes experienced by professionals in residential care for children and youths, an interdisciplinary team approach that advocates paraprofessional participation is strongly supported. Clearly, professional clinicians have a role to play at the project center. That role must not counteract the positive contributions of the paraprofessional. From experience, the writer has found that professionals are often the least likely to understand client dynamics beyond their limited expertise. The proper use of the professional is in the expansion of possible solutions for the treatment of difficult clients, not in making all the vital treatment decisions because of their training and professional status (Ryback, 1974).

2. The interdisciplinary team approach is holistic and people-centered (Buchanan & Rogers, 1980). Its effectiveness has been demonstrated in hospice care (Grady & Wilson, 1981; English and Mortenson, 1981a, 1981b), in a medical facility for the elderly (Block et al., 1987), in psychiatric hospitals (Ryback, 1974), and in residential programs for children and youths (Garner, 1988; Krueger, 1990; Munson et al., 1989; Vorrath & Brendtro, 1985). The interdisciplinary approach promotes service coordination, minimizes cross-purpose planning (Munson et al. 1989; Ryback, 1974), and compensates for individual staff weaknesses (Garner, 1988).

The writer was not convinced that a total egalitarian approach to treatment planning is efficient or necessary to provide interdisciplinary treatment strategy. Consensual decision-making is difficult (Tannenbaum & Schmidt, 1958).

Bailey, Helsel-DeWert, Thiele, and Ware (1983) reported that treatment teams are influenced by the size, composition, experience, and roles of the individual members, and team pressure may limit individual creativity. The democratic process of team work is slow. Individual problems between members may detract from the team's primary function (Toseland et al., 1986). Wilson and Grady (1981) described one hospice team that assumed all treatment decisions must have the majority vote of all members of the treatment team, resulting in too much time spent on negotiations and failure to provide specific treatment objectives. The goal of the practicum was not to abolish clearly defined departmental lines and job descriptions, or subject treatment decisions to a majority vote, but to include staff members from the three departments in the decision-making process.

To counter possible confusion within the interdisciplinary team, Krueger (1983, p.15) outlined the characteristics of organizations with functional interdisciplinary treatment teams:

> (a) There is a strong commitment among administrators to promote professional equality for all team members;
> (b) In-service training emphasizes teamwork, communication, and report and of observing skills;
> (c) Working conditions and incentives are comparable for most team members;
> (d) All team members have an opportunity to attend team decision-making meetings.

The project center was in a position to initiate an interdisciplinary team approach to treatment planning. There was a strong commitment among all staff members to provide optimal care for the residents. In-service training provided team building exercises for the three paraprofessional treatment teams. It was possible to open this process to include the professional and school staff. Implementing an interdisciplinary team approach would provide interdepartmental participation in the treatment planning process. Implementation did not require additional overtime or the removal of child care workers from their line duties.

3. Ryback's (1974) suggestion that the treatment plan should reflect more than the therapeutic hour and must be written in a language common to all levels of staff on the team was well-received by this writer. Assignments must not be based upon professional status alone, but on which team member is best suited to provide the service (Garner, 1988; Ryback, 1974; Toseland et al., 1986).

Treatment plans were too complicated in the departmental formats at the center prior to implementation of the practicum. A single coordinated, interdisciplinary treatment plan needed to be developed for specific use during the implementation phase, a plan that reflects the consolidated efforts of staff members who have regular contact with the residents and provided formal guidelines and therapeutic goals and interventions used by both the professional and the paraprofessional. Specific goals should be based on resident needs, and not on arbitrary program design (Vorrath & Brendtro, 1985).

With monthly amended treatment plans, target behaviors, goals, and intervention techniques would better reflected current needs and assessment. The treatment plans would no longer be formalized rituals with little meaning for the daily needs of residents and the staff who have to provide services.

Description of Selected Solution

The primary goal of the practicum was to improve the development and implementation of treatment planning. Providing consistent, meaningful treatment in a residential facility for adolescent boys is a difficult task. In reviewing the literature and discussing possible solutions with staff members at the center, implementation of an interdisciplinary team approach to treatment planning could achieve the goals of the practicum. Many services were provided to the residents by a well-trained, educated and motivated staff prior to implementation of the practicum. The center prides itself in its effective use of a peer group model. Expanding the consensual decision-making process of the group model to the staff level was feasible and desirable.

Through implementation of the practicum, the solutions strategies would provide needed improvement in the three discrepancies reported in Chapter II, and the goals and objectives described in Chapter III.

1. The child care workers have been frustrated because of their exclusion from the formal treatment planning process. This process has been the exclusive domain of the directors, supervisors, and clinicians. With the inclusion of the child care workers in the process, they would no longer be isolated from professional participation. Their roles would be redefined in professional terms, valuing their unique perspectives and experiences with the residents in the living unit. This is a vital part of a total team concept.

Because the child care workers would functioned as advocates for the residents on their caseloads, they were in a position to hold other members of the team accountable for services provided much the same way a parent would hold accountable a physician or teacher. They do not have to compete with the education and expertise of the clinicians and teachers, but they could question specific goals and clarify procedures.

2. By implementing an interdisciplinary team approach, the division between departments at the center could be

substantially reduced. Cross-purpose planning should diminish because resident needs, assessments, and possible intervention techniques would be fully discussed by the members of the team.

During the implementation phase, the center would assign members from the three department (paraprofessional, professional, school) to one of three treatment teams. The teams would provide basic services and therapy for thirteen or fourteen residents. All treatment decisions would be subject to full discussion by the teams. Each team would be responsible for assessing resident needs and goals, and assigning team members to various tasks.

With the inclusion of the clinicians, teachers, and teacher assistants on the treatment teams, a coordinated treatment strategy should emerge reflecting the efforts of the three departments. The paraprofessional child care workers would participate in the process for the first time. The counseling team supervisors would become aware of specific needs and goals to be accomplished by the clinicians and the school. The clinicians would become aware of the treatment decisions of the paraprofessional staff, and school staff would know the treatment goals and strategies at the residence. Success in the implementation of an interdisciplinary team approach would diminish the isolation felt by staff members in each department and improve the total treatment program at the project center.

3. A single treatment plan needed to be developed that would include presenting problems, targeted behaviors, goals and interventions from the three departments. The new treatment plan should be modeled after the Individual Educational Plan (IEP) utilized by most school districts and at the center's non-public school. Essentially, the IEP allows for interdisciplinary goals on a single form, signed by all participants on the eligibility and planning committee. By incorporating the IEP format into the center's treatment plan, a coordinated analysis and assessment of target behaviors, treatment goals, and intervention techniques could be achieved.

Treatment plans needed to be reviewed and updated monthly for each resident. Short-term 30 day goals would become the focus to the monthly revised plans, documenting achievements, failures, and continuing interventions from the three departments. The consolidated treatment plan should be signed by all members of the interdisciplinary team. This should allow for a more consistent treatment strategy between departments. The first consolidated plan provided specific goals and interventions developed by the interdisciplinary team:

Page 1	Resident demographics and case history, psychological/ psychiatric assessments
Page 2	Long term goal (residential, clinical, family involvement, educational, discharge

	planning)
Page 3	Short-term milieu/living unit goals and interventions
Page 4	Short-term clinical goals, including the use of psychotropic medications.
Page 5	Short-term educational goals

Page 1 and 2 of the new consolidated plan would not be amended monthly unless new information regarding resident demographics and case history changed the long-term goals established at intake. Pages 3, 4, and 5 of the plan would be updated at the conclusion of each interdisciplinary team review.

Implementing a consolidated interdepartmental plan should significantly decrease cross-purpose planning and interventions, and provide staff members from each department important information about the particular treatment efforts of other staff members. If successful, the consolidated plans should provide an appropriate solution to the third problem/goal of the practicum.

Report of Action Taken

Upon approval of the proposal, the 12 week implementation phase of the practicum commenced the week of June 30, 1991. All direct child care staff at the residential center (directors, clinicians, supervisors, and caseload counselors), the teachers, teacher assistants, school social worker at the center's non-public school, and the agency's psychologist and consulting psychiatrist participated in the implementation of the interdisciplinary team approach to treatment planning. After the 3 month implementation phase, 4 weeks was devoted to assessment and evaluation of the interdisciplinary team process.

The writer directed the process and aided staff members in defining staff roles, evaluating team guidelines, and amending treatment team formats. Staff members affected by the implementation of the practicum were asked to identify potential problems, personal concerns, and offer potential solutions. The decision to implement an interdisciplinary team approach had the approval and support of all staff members and the agency's executive director.

During the implementation phase, the center reorganized the administrative structure to allow treatment planning to include teachers, teacher assistants and the child care workers. The center devoted substantial in-service training to the interdisciplinary treatment team approach. Through individual team and general staff meetings, all staff members had the opportunity for input into the transition from departmental treatment planning to an interdisciplinary team approach, to evaluate the transition's progress, and to develop new treatment assessment tools.

The first task of administration was to redefine individual staff roles. Each member of the interdisciplinary team had a unique perspective to offer and a unique role to play. At the beginning of the implementation phase, a special in-service training session conducted by the writer helped staff members to redefine individual staff roles. Staff participated in the process of determining their functions on the new treatment teams.

Of primary importance was the redefining of the paraprofessional child care workers' role at the project center. In the new interdisciplinary treatment teams, the child care workers became the primary provided of care by assuming the role of child advocate or "parent" for the residents on their caseloads. The child care workers became responsible for presenting case histories, court-ordered treatment goals, and the residents' needs within the living unit. The child care workers became responsible for the coordination of all treatment services provided to the residents. As a parent is responsible for the health, safety, and well-being of their child by making medical appointments, taking the child to the dentist, meeting with school teachers and administrators, and providing daily nurturance, the child care workers as child advocates would assure that the residents were on time at school or for individual clinical session, did their homework, were present, ate a balanced diet, etc. The child care workers as child advocates were in a position to question treatment goals and interventions prescribed by the professional staff. The child care workers as child advocates were in a position to question and grant permission.

The administration had to redefine the roles of the directors at the center. In the past, the directors were the leaders in the treatment planning sessions. Upon implementation of the practicum, the directors relinquished direct leadership control of the process to allow the three teams to set team agendas and provide treatment assessment and planning. The directors assumed the role of consultants, supporters of the team process, and helped the teams keep on track. This allowed the teams to function independently but within basic guidelines established by the administration.

Three interdisciplinary treatment teams were formed. The initial guidelines under which the interdisciplinary teams operated were as follows:

1. Teams will be represented by staff from the three departments (paraprofessional, professional, school).
2. Each team will include the counseling team supervisor, assistant team supervisor, counselor II, and two counselor I currently assigned to the treatment teams. In addition, a clinician, a teacher, and a teacher assistant was assigned to the teams.

3. Each week three resident plans will be reviewed by the interdisciplinary team. A total of nine residents will be reviewed weekly by the three teams.
4. The three caseload counselors on the team will rotate weekly, presenting their caseloads for review. Through weekly rotation, caseload counselors on vacation will not affect the weekly planning session, and this will allow the caseload counselors to attend *every* planning session when residents on their caseloads are being reviewed.
5. The director, director of treatment, director of clinical services, psychiatrist, and psychologist will rotate weekly between the teams.
6. The psychiatrist and psychologist will be available before the team meetings to consult with team members who have specific questions regarding psychological/psychiatric assessments and the use of psychotropic medications.
7. Teams will have allotted time each week to discuss team concerns.
8. A consolidated initial or revised treatment plan documenting the treatment goals and interventions of the three departments will be developed for each resident reviewed.
9. Each member of the team will have equal status.

10. Initially, the counseling team supervisors will chair the team. However, the supervisors must demonstrate an ability to provide a coordinated treatment agenda. Leadership of the team will be subject to change should a supervisor not facilitate the consensual process. Any member of the team who demonstrates the ability to facilitate the process can be designated by management as the team leader.

These guidelines were a starting point for the implementation phase. They were subject to discussion, evaluation, and amendment by staff members involved in the interdisciplinary teams through monthly staff meetings throughout the implementation phase.

The interdisciplinary teams met each Wednesday afternoon for 2 1/2 hours:

1:30 to 2:30-- Review of resident treatment plans
2:30 to 3:00-- Team discussion of issues and concerns
3:00 to 4:00-- Debriefing with teams and directors

Practicum Implementation

Week 1

The first draft of the new interdisciplinary treatment plan (see Appendix A) was developed and distributed to the teams. The teams were asked to review the plans and be prepared to offer suggestions within 1 week.

A general staff meeting was convened. All members who were to participate in the new interdisciplinary team approach were present. The general guidelines of team responsibility as outlined above were reviewed. The staff was divided into three treatment teams with each department represented in each of the three teams. After the general staff meeting the three teams met separately to discuss team responsibility and individual team members' roles within the new treatment planning process. Each team was asked to define individual staff member roles as well as how the team would arrive at coordinated treatment decisions (by team consensus or by a majority vote). The teams were asked to respond to a questionnaire (see Appendix B) that was designed to guide them through this process. All three teams decided that treatment decisions would be arrived at by team consensus.

Week 2

The three interdisciplinary teams met separately for the second time. During the meeting, the teams were asked to respond to a written questionnaire (see Appendix C). The task of the second meeting was to further define individual staff roles, finalize as many aspects of how the team will function in arriving at and documenting treatment decisions, and how the treatment process will operate within the team.

Week 3

A general staff meeting was convened for all participants in the interdisciplinary teams. The director of treatment and a senior clinician distributed the newly updated interdisciplinary treatment plan (see Appendix A) and provided in-service training on the use of the new plan. Staff input from the previous meetings provided additional information that needed to be included on the treatment plan. The new interdisciplinary plan was revised a third time and incorporated basic intake information, a quick-reference assessment of short-term treatment concerns and the actual goal sheets.

The three interdisciplinary teams met separately for the 3rd week. A third questionnaire (see Appendix D) was distributed to the teams. The teams were asked to discuss and report how the team will complete the new interdisciplinary treatment plan (see Appendix A), what team member will be responsible for completing the plan and distributing it to the treatment and school files and to other members of the team, and whether individual members of the team or the team as a whole will be responsible for different sections on the treatment plan.

Week 4

A general staff meeting was convened. All staff members of the three interdisciplinary treatment teams attended. The writer spoke to participants about the consensual decision-making process. The writer stated that at this time the teams would not be judged by the contents of the treatment plans, which are often a smoke screen used by dysfunctional teams. If the team is functional, then the treatment plans would eventually reflect that functionality. It was important for team members first to learn to communicate and contribute to the process.

The writer monitored Team One. The team did not come completely prepared. The preliminary assessment of the residents were not completed by staff, which led to an excessive use of time, resulting in the review of only one resident. The team realized its mistake and decided to complete preliminary work prior to the meeting so that they could concentrate on the exchange of ideas and full treatment plan development within the 20 minute time limit.

The 30 day goals for the resident were very general. The writer asked, "What will the result to the goal look like in 30 days?" The caseload counselor could not answer. The first goal was to work on "Improving Impulsivity." The caseload counselor redefined the goal to a reduced number of verbal acting out incidents of two per week, which is a goal that could be tracked and achieved within 30 days. The writer explained that it did not matter if the goal was achieved or not. What was important was that all treatment goals were detailed in such a way that they could be tracked and demonstrated as either achieved or not achieved.

Interestingly, the special education teacher was not only able to state a specific goal of increasing the resident's mathematic skills from the sixth grade to the eighth grade during the next year, but also outlined the plan for achieving the goal:

> For the next 30 days, the school would work on the multiplication table and fractions (specifically, the denominator).

The teacher's plan was by far the best. It not only expressed a long term goal, but also a specific 30 day goal that would lead to achievement of the yearly goal. The writer brought this to the team's attention and explained that the new treatment plan was simply an extension of the IEP process. Therapeutic and behavioral goals must be stated in not only what is to be the expected outcome, but how the outcome will be achieved in a short-term 30 day schedule.

The team suggested that the assessment part of the treatment plan be rated according to a Likert Scale--5 points:

1. Strongly Disagree
2. Disagree
3. Unknown, Unsure, To be investigated
4. Agree

5. Strongly Agree.

The use of the Likert Scale would make it easier for team members to identify those areas of concern that need to be prioritized for the thirty day treatment plan. The scale was incorporated in the new plan format.

Week 5

The director of treatment combined the floor and clinical files into a single treatment file. The writer monitored Team Two. Only two residents were reviewed.

The information presented by the caseload counselor was relevant and timely, but the treatment goals were too global. The goals had to be refined to 30 day achievable goals. Both the caseload counselor and the clinician talked about the residents chronic depression, yet there was no mention of referral to the psychiatrist or the use of psychotropic medication. As it turned out, the resident was on 75-mg of desipramine. The clinician admitted not seeing the resident in 2 or 3 weeks, and the caseload counselor was not aware if the resident had seen the clinician. The teacher and teacher assistant did an excellent job describing the resident's current IEP status at the school, and defined short-term goals for reading.

The second resident was reviewed, and the caseload counselor and clinician were better prepared with specific information regarding the resident's family situation, his status within the accountability group, and his improved behavior during the last 6 weeks. The teacher assigned to the caseload was on vacation and did not leave any information regarding school performance or goals. This was a major gap in the development of the treatment plan.

Week 6

A general staff meeting was convened with all participants in the interdisciplinary teams. The following ideas and suggestions were discussed.

1. The clinical assessment section should be on a separate page from the caseload counselor to allow for more information and for the two parties to have separate sheets to work on before the meeting. This would prevent having to exchange a single sheet during the week.
2. All three teams agreed to change the assessment part of the treatment plan, adding a Likert Scale.

The writer monitored Team Three. Overall, it was an excellent meeting, egalitarian in nature. The supervisor did not dominate the meeting as the writer would have expected in this team. The treatment reviews were concise and informative. Emphasis was placed on short-term goals that could be documented. This was difficult for the caseload counselor and the clinician, but with effort, goals were laid out in precise operational definitions that could be measure for success the next time the resident was reviewed.

Week 7

The writer monitored Team One for the second time since implementation of the practicum. Three residents were reviewed averaging 20 minutes per resident. All members of the team were prepared. Again, the writer had to emphasize measurable goals for the next 30 days. This team was the first to incorporate the Likert Scale for the assessment tool. It was very instrumental in helping the team members to focus on the most important issues and goals.

Week 8

The writer monitored Team Two. There was a noticeable improvement of the first monitored visit. Because this was the last week of the 5 week cycle, only one resident was scheduled for review. The review was timely and well-coordinated by caseload counselor, who was acting team leader in the absence of the vacationing counseling team supervisor. Input from the three departments was pertinent and appropriate. Regarding the development of problems and goals, the writer asked the team the following questions:

1. What was the problem/concern that needed correction?
2. How did staff member know this was a problem?
3. What evidence was there that this was a problem?

4. What are the expected long-term and short-term goals?
5. What do we expect to change during the next 30 days?
6. How can this goal be achieved?

The staff reacted favorably to these questions. They were beginning to understand the need to demonstrate a measurable problems and measurable goals.

Week 9

The writer monitored Team Three. The meeting was timely with most items for the new treatment plan well formulated prior to the meeting. The team did not use the 30 day assessment tool for revised plans. The writer advised them of the necessity to use the 30 day assessment tool each time a residents treatment plan was reviewed. The team made the appropriate adjustments.

The team had problems identifying treatment goals that were measurable and that could be demonstrated and tracked. This continued to be a significant problem for all three teams. Otherwise, it was a very professional, productive meeting with all members participating and contributing to the process.

Week 10

A general staff meeting was convened with all participants in the interdisciplinary treatment teams to discuss implementation of the interdisciplinary team approach to date. Staff suggested that the new treatment plan provide a section for the resident's anticipated date of graduation (where, whom, when?, etc.). This was incorporated into the new plan.

The writer monitored Team One. This is by far the best group in adopting interdisciplinary team approach. Three residents were reviewed. All parties were well prepared, with each review averaging 20 minutes. Specific goals were both measurable in terms of problem statements, goals, and treatment intervention.

Week 11

The writer monitored Team Two for the third time. It was a very good session. The teacher presented measurable goals. The counseling team supervisor (team leader) actively asked team members for measurable goal--to refine goals, have a base measurement to demonstrate that there is a problems, a measurable 30 target goal, and a proper intervention that would achieve that goal.

The team was able to complete three treatment reviews in 70 minutes. Things have improved measurable during the last 3 weeks.

Week 12

The writer monitored Team Three for the third time during the implementation phase. All participants came well prepared, but there was a lack of focus. It took more than 30 minutes to complete a single review. The team leader was not focused, wanted too many details, and mostly controlled the process.

Of particular interest was the school's presentation in the process came last. The structure was very institutionalized and the team members appeared to be inhibited. The writer placed most of the fault on the team leadership.

Assessment of the Practicum

Following the implementation phase of the practicum, a 4 week period of assessment of expected outcomes was conducted by the writer. During the 1st week, the writer interviewed 13 caseload counselors (11 counselors who were employed at the beginning of the practicum and 2 additional counselors who were added to the staff after the implementation phase was initiated). The counselors were asked to respond to six questions defined in Chapter III.

During the 2nd week of the assessment period the writer interviewed the counseling team supervisors, clinicians, and teachers. These staff members were asked to respond to the five questions outlined in Chapter III.

During the 3rd week of the assessment period, the writer randomly selected 10 resident treatment files to determine if the new interdisciplinary treatment plans contain proper documentation that either achieve or not achieved the expected outcome in Chapter III. Also, during the week, the writer interviewed the director of treatment, the school principal, school social worker, and the center's psychologist and consulting psychiatrist. These staff members were asked to respond to the five questions in Chapter III.

Due to resignation, the director of clinical services was asked to respond to the questionnaire during the 11th week of the implementation phase. With the exception of this one unforseen resignation, and the numerous revisions to the new interdisciplinary treatment plan, there were no other deviations from the practicum proposal.

CHAPTER V

RESULTS, DISCUSSION, AND RECOMMENDATIONS

The problem addressed by the practicum was the lack of coordination of treatment planning between professional, paraprofessional, and school staff at a residential facility for adolescent males. The lack of cooperation between departments led to frustration among staff, cross-purpose treatment planning, and treatment plans that were quickly outdated and of limited value. Through implementation of the practicum, an interdisciplinary team approach for treatment planning was adopted by the agency.

Results

1. The first expected outcome of the practicum was to increase the involvement of the paraprofessional child care workers in the treatment planning process so that they would feel less frustration, achieve a higher level of job satisfaction, and would have more investment in the implementation of specific treatment objectives. The first expected outcome was measured by: (A) a questionnaire demonstrating paraprofessional involvement in the treatment decision making process; and (B) fewer incident reports

documenting resident disrespect and verbal abuse of child care workers.

(A) After the implementation phase, the writer questioned the 11 child care workers (and 2 new child care workers employed after the start of the implementation phase) using the questionnaire in Chapter III.

Question 1

How often was the paraprofessional caseload counselor consulted by counseling team supervisors regarding residents on their caseloads?

All 11 caseload counselors responded that they consulted with the counseling team supervisor at least once a week during the 3 month implementation phase. This exceeded the goal of 8 of the 11 caseload counselors responding that they were consulted weekly by the supervisors regarding treatment decision for the residents on their caseloads. In addition, the two new caseload counselors who were employed after the beginning of the implementation phase also responded that they were consulted weekly.

Question 2

Since implementation of the practicum, how regular was the caseload counselors' participation in the treatment planning sessions?

All 11 caseload counselors responded that not only were they present at all interdisciplinary team meetings when the residents on their caseloads were reviewed, but they had participated in every interdisciplinary team meeting when residents of other caseload counselors on the team presented case reviews. Also, the two new caseload counselors reported that within the first month of employment they had receive caseloads of two residents each, and from the beginning they participated regularly in the weekly treatment planning sessions. The result exceeded the goal of 8 of the 11 caseload counselors responding that they attended every treatment planning session when residents on their caseloads were reviewed.

Question 3

Was the caseload counselors' experience with the residents in the living unit and ideas about appropriate treatment goals and interventions equal to the input from other members of the treatment team (supervisors, clinicians)?

The goal would be achieved if 8 of the 11 caseload counselors reported that their input into the process was at least equal to that of other members of the team. This goal was achieved, as all 11 caseload counselors reported that their input was at least equal to other members of the team, and 3 of these 11 counselors reported that their input was more than equal to other members of the team.

The two new caseload counselors responded to the question by stating at first their input was not equal to that of other members of the team, but after 4 to 5 weeks of employment, their input was increasing as they gained more insight and understanding of their job responsibilities.

Question 4

Has the caseload counselors' position at the center been enhanced by the practicum implementation? If yes, how? If no, what suggestions do they have to improve their participation in the treatment planning process?

It was expected that 8 of the 11 caseload counselors would experience a positive change in their roles (from paraprofessional behavioral managers to equal members of a professional treatment team). All 13 caseload counselors, including the 2 new counselors, responded that the implementation of the interdisciplinary team approach had definitely enhanced their positions at the center. A typical response from the counselors was that with their inclusion into the process they had an enhanced understanding of resident behavioral dynamics, and through participation in the interdisciplinary teams they realized how important was their contribution to the treatment team and the agency as a whole. The new counselors could not compare their experience in the interdisciplinary teams with how things were in the past at the agency, but one of the new counselor related a previous experience at another residential facility where child care workers were relegated to strict behavior modification program. This counselor reported that the agency's emphasis on paraprofessional involvement in treatment planning was stimulating, encouraging, and far superior to therapeutic approaches where treatment decisions are made only by professional staff.

Question 5

Since implementation of the practicum, have the caseload counselors experienced less frustration?

This goal would be considered achieved if 8 of the 11 caseload counselor responded that they had experienced less frustration. This goal was achieved in that 9 of the 11 caseload counselors responded that they had experienced less frustration because of their inclusion in the treatment decision-making process. The new caseload counselors responded that they had not experienced less frustration because the new format required more effort and commitment. They preferred the new system, only stating that they needed more in-service training on how to define measurable treatment goals. The two new counselor chose not to respond to this question because they were not at the center long enough to notice any significant change in the frustration level experienced by the paraprofessional staff.

Question 6

Since implementation of the practicum, do treatment plans reflect caseload counselors' goals?

This goal would be achieved if 8 of the 11 caseload counselors responded positively. All 13 caseload counselors, including the 2 new counselors, responded that the treatment plans did incorporate their ideas, treatment goals, and intervention techniques.

B. A second measurement for the success of the first expected outcome was a reduction in the number of incident reports dealing with resident disrespect and verbal abuse of caseload counselors from the monthly average of 13 reports during January, February, and March 1991, to an average of seven reports per month during the three month practicum implementation phase. This goal was not achieved. The number of incidents per month during the implementation phase were:

1st month	--14
2nd Month	--11
3rd Month	-- 8
Monthly Average	--11

2. The second expected outcome of the practicum was an improvement in the coordination between members of different departments in the development and implementation

of treatment strategies, resulting in less cross-purpose planning. This expected outcome was measured by interviewing the professional staff (the director of clinical services, the clinicians, and the clinical interns), the three counseling team supervisors, and the four teachers at the center's non-public school to determine if cooperation between the three departments had improved since implementation of an interdisciplinary team approach. The outcome would be considered successful should 9 of the 12 professional staff members responded positively to five questions developed in Chapter III.

Question 1

How often did staff members from the three departments consult each other regarding specific treatment decisions?

This goal would be considered successful if 9 of the 12 professional staff members reported that they had consulted weekly with staff members of different departments. This goal was achieved by the implementation of the interdisciplinary team approach. All 12 professional staff members reported that they had consulted members of other departments each week during the 3 month implementation phase. Seven of the 12 professional staff members reported that they consulted with members of different department more than once a week.

Question 2

Since implementation of the practicum, how has the position in each department improved?

This goal would be considered successful if 9 of the 12 professional staff members reported that interdepartmental communication had improved, thus enhancing their positions at the center. This goal was achieved. Eleven of the 12 professional staff members reported that there was a significant improvement in the cooperation and communication between departments. One professional staff member reported that only during the last 2 to 3 weeks of the implementation phase was there a noticeable improvement in communication with other members of the interdisciplinary team.

Question 3

Has their professional relationship with the paraprofessional caseload counselors improved during the implementation phase?

This goal would be considered successful if 9 of the 12 professional staff members interviewed reported that their relationship with the caseload counselors had improved because of the implementation of the interdisciplinary team approach. All 12 professional staff members interviewed reported that there has been significant improvement in their relationships with the caseload counselors. The three counseling team supervisors reported that the caseload counselors' attitude toward their job and support of treatment goals had improved significantly, and therefore, supervision was made easier. The two clinicians and two clinical interns expressed a major improvement in regular communication with line staff. Three of the four teachers reported because of the information gathered from caseload counselors during the interdisciplinary team meetings they were more aware of the needs of the line workers, thus increasing the teachers' appreciation of the unique responsibilities of the child care workers at the center. This goal was achieved.

Question 4

Since implementation of the practicum, has there been an improvement in the coordination of clinical, paraprofessional, and school treatment objectives.

This goal would be considered successful if 9 of the 12 professional staff members interviewed reported that there has been significant improvement in coordinating treatment objectives with other departments. This goal was achieved. Eleven of the 12 professional staff members interviewed reported that there has been significant improvement in coordination, cooperation, and communication with members from other departments. Only one teacher reported that there was not a significant improvement in cooperation until the last 2 or 3 weeks of the implementation phase.

Question 5

Do the treatment plans reflect crucial interdisciplinary objectives?

This goal would be considered successful if 9 of the 12 professional staff members interviewed reported that the new treatment plan format included vital interdisciplinary concerns. This goal was achieved with all 12 of the professional staff members reporting that there has been significant improvement in the documentation process of interdisciplinary goals, and that the new treatment plan format helped team members focus on the goals of other departments.

In reviewing the implementation of the interdisciplinary team approach with the director of treatment and the director of clinical services, both directors expressed concern about their roles within the new process. It was a major concern of the director of clinical services about how to hold the clinical staff accountable for departmental responsibilities while supporting interdisciplinary decisions that may be contrary to professional clinical concerns. The director of treatment was concern about how to guide the process without undue interference. Also, it was the writer experience during the implementation phase that it difficult to advise the three teams without dictating what decision were to be made.

3. The third expected outcome of the practicum was an improved format treatment plan that reflected current information and interdepartmental strategies. As part of the solution strategy reported in Chapter IV, the paraprofessional/milieu treatment plans and clinical treatment plans were incorporated into a single treatment plan utilized by all treatment staff. To measure this outcome, the writer randomly selected 10 resident treatment files (files 1 to 5 for review of paraprofessional/milieu planning and files 6 to 10 for review of clinical planning). Only residents in the program for the entire period of the implementation phase were subject to selection. Seventeen specific items were reviewed to determine success of this expected outcome according to the goals established in Chapter III:

(1) Four of the five paraprofessional/milieu and clinical treatment plans have been reviewed monthly during the implementation phase.

(2) Four of the five paraprofessional/milieu and clinical treatment plans have documented resident case histories.

(3) The number of paraprofessional/milieu treatment

plans that document specific 30 day paraprofessional treatment goals increased from one to four.

(4) The number of paraprofessional/milieu treatment plans that document specific treatment interventions, modalities, or referrals for specific 30 day targeted day behavioral goals increased from one to four.

(5) The number of paraprofessional/milieu treatment plans that document specific clinical treatment goals increased from zero to four.

(6) The number of paraprofessional/milieu treatment plans that document resident Special Education Classification (Sp. Ed. Class.), if applicable, increased from zero to four.

(7) The number of paraprofessional/milieu treatment plans that document specific educational/school goals increased from three to four.

(8) The number of paraprofessional/milieu treatment plans that document specific resident family goals or emancipation planning increased from three to four.

(9) The number of paraprofessional/milieu treatment plans that document specific discharge planning increased from two to four.

(10) The number of clinical treatment plans that document specific 30 day clinical treatment goals increased from three to four.

(11) The number of clinical treatment plans that document specific treatment interventions, modalities, or referrals for specific 30 day clinical treatment goals increased from three to four.

(12) The number of clinical treatment plans that document specific paraprofessional/milieu treatment goals increased from one to four.

(13) The number of clinical treatment plans that document resident Special Education Classification (Sp. Ed. Class.), if applicable, increased from zero to four.

(14) The number of clinical treatment plans that document specific educational/school goals increased from two to four.

(15) The number of clinical treatment plans that document specific resident family goals or emancipation planning remained at four.

(16) The number of clinical treatment plans that document specific discharge planning increased from zero to four.

(17) The justification and use of psychotropic

medication was documented on every treatment plan (both the paraprofessional and clinical plans) for residents prescribed these medications.

The results of the review are detailed in the following table (see Table 3). Because the former departmental paraprofessional and clinical treatment plans were consolidated into a single interdisciplinary treatment plan during the implementation phase, the 17 items reviewed are separated into three categories:

1. Items 1, 2 and 17 are common to both former plans as detailed in Chapter II.
2. Items 3 to 9 are in reference to problems documented in Chapter II regarding the former paraprofessional/milieu treatment plans.
3. Items 10 to 16 are in reference to problems documented in Chapter II regarding the former clinical plans.

Table 3

Items That Should Be Present in the Paraprofessional and Clinical Sections of the New Interdisciplinary Treatment Plans

Items Reviewed	Resident File Number										
	1	2	3	4	5	6	7	8	9	10	Total
(1) 30 Day Review	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/10
(2) Case History	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/10
(3) 30 Days Goals	Yes	Yes	Yes	Yes	Yes	N/A	N/A	N/A	N/A	N/A	5/5
(4) Interventions	Yes	Yes	Yes	Yes	Yes	N/A	N/A	N/A	N/A	N/A	5/5
(5) Clinical Goals	Yes	Yes	Yes	Yes	Yes	N/A	N/A	N/A	N/A	N/A	5/5
(6) Sp. Ed. Class.	Yes	Yes	Yes	N/A	Yes	N/A	N/A	N/A	N/A	N/A	4/4
(7) School Goals	Yes	Yes	Yes	Yes	Yes	N/A	N/A	N/A	N/A	N/A	5/5
(8) Family Goals	Yes	N/A	Yes	Yes	Yes	N/A	N/A	N/A	N/A	N/A	4/4
(9) Discharge Plan	Yes	N/A	Yes	Yes	Yes	N/A	N/A	N/A	N/A	N/A	4/4
(10) 30 Day Goals	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes	Yes	Yes	5/5
(11) Interventions	N/A	N/A	N/A	N/A	N/A	Yes	Yes	No	Yes	Yes	4/5
(12) Para. Goals	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes	Yes	Yes	5/5
(13) Sp. Ed. Class.	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes	Yes	Yes	5/5
(14) School Goals	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes	Yes	Yes	5/5
(15) Family Goals	N/A	N/A	N/A	N/A	N/A	Yes	Yes	N/A	N/A	Yes	3/3
(16) Discharge Plan	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes	Yes	Yes	5/5
(17) Psycho. Meds	Yes	Yes	Yes	N/A	N/A	N/A	Yes	N/A	N/A	N/A	4/4

The results in measuring the third expected outcome exceeded the goal. All 17 items were present in either the paraprofessional or clinical sections of the new interdisciplinary treatment plans. In item 6, Special Education Classification documentation in the paraprofessional section of the treatment plan, only four residents had been designated as qualified for special educational services. In items 8 and 9, specific family goals and discharge planning in the paraprofessional section of the treatment plan, one resident did not have a family with which to be reunited, therefore, only four of the five plans reviewed were subject to review on these items, and only three of the five residents' files reviewed for clinical goals and discharge planning (item 15) were of residents who had families with which to be reunited.

The only item missing in either section of the plan was for item 11. One clinical section reviewed did not have specific treatment interventions, modalities, or referrals for the specific 30 day goals established by the interdisciplinary plan.

Discussion

The expected outcomes anticipated by implementation of the practicum were achieved. The results of implementing an interdisciplinary team approach to treatment planning has increased the paraprofessional child care workers' investment in treatment planning and follow-up strategies, has provided a better format for coordination of treatment objectives and communication between departments, and has produced a new interdisciplinary treatment plan that capitalizes on the improved interdepartmental communication with consistent treatment strategies that are timely and provide guidance to all treatment staff at the project center.

1. The first expected outcome was an improved level of job satisfaction among the paraprofessional child care workers. The outcome was achieved in that all 11 of the caseload counselors who were at the center at the beginning of the implementation phase reported substantial improvement in how they were perceived at the center, how the residents perceived them, and how their unique ideas are incorporated into a holistic treatment approach.

The second measurment of this outcome was not achieved. It was anticipated that the average number of incident reports dealing with resident verbal abuse and disrespect of the child care workers would have decreased from the monthly average of 13 before implementation of the interdisciplinary team approach to a monthly average of 7. The monthly average of 11 incident reports actually achieved during the implementation phased far exceeded the goal. However, the trend during the 3 month implementation phase was down, from a high of 14 for the first month, to 11 during the second month, and only 8 during the last month. This would suggest that the limited 3 month implementation period was not sufficient to measure a secondary result. It may prove that over a period of 12 months, the goal may be achieved.

The significance of the paraprofessionals' involvement in the treatment decision-making process is in the inclusion of their unique perspective from their daily routines in the living unit. The frustration endured by paraprofessional child care workers is only increased when their duties are relegated to behavioral management of the residents. As Krueger (1983) reported, the use of child care workers in the treatment decision-making process often breaks the circular effects of client dysfunctional behavior. Block's et al. (1987) study demonstrated clients benefitted when the paraprofessional's knowledge was incorporated in a total treatment at a nursing home for the elderly.

At the project center, the caseload counselors were enthusiastic about their roles within the treatment decision-making process, and their involvement in the treatment teams had increased their personal involvement and job satisfaction as Krueger et al. (1986) and Munson et al. (1989) predicted.

2. The second expected outcome of the practicum was achieved. The interdisciplinary team approach implemented at the project center provided a wider range of staff perspectives. Many studies have demonstrated the implementation of an interdisciplinary team approach fosters improved coordination, communication and support for staff not available in the archaic medical/social worker model (Garner, 1988; Hermary & Rempel, 1990; Hochstadt & Harwicke, 1985; Ryback, 1974; Vorrath & Brendtro, 1985). This was the case at the project center. The holistic team approach provided the interdisciplinary teams with a wider scope of possible treatment strategies. It provided a forum for staff from all departments to share specific ideas.

Because of the involvement of many staff members who were previously excluded from the treatment decision-making process, resident cases were reviewed three times more frequently than before implementation of the practicum. This allowed for concentration on specific treatment issues not available before the implementation of the practicum.

3. The third expected outcome was also achieved. Because resident treatment plans were reviewed monthly during the implementation phase, treatment goals and intervention strategies were fresh on the minds of staff members. The new interdisciplinary treatment plan provided for an

operational strategy based on shared, interdepartmental information giving a complete picture of the residents' needs.

Treatment planning is a priority at any residential center. The new interdisciplinary treatment plans reflected interdepartmental observations, concerns and strategies. It provided each resident with an individualized plan based on the input from all staff members involved in providing treatment services and increased the ability of formal treatment planning to impact daily staff/resident interactions.

The implementation of an interdisciplinary team approach did not provide a panacea. It was not the object of this practicum to analyze individual treatment goals. The goal was to provide staff with an instrument that allowed them to focus on crucial issues. This was achieved. However, the single, most common concern expressed by staff members when assessing their involvement in the interdisciplinary team approach was the difficulty in analyzing and developing measurable treatment goals.

Recommendations

After evaluating the implementation of an interdisciplinary team approach to treatment planning, there are two areas that need further study:

1. A majority of staff members, including all 13 caseload

counselors who were involved in the implementation phase, expressed concern about developing measurable goals. Clearly, more in-service training and further study and action in goal analysis and development would be useful. The practicum only addressed how staff members from different department worked with each other. It did not train staff members how to recognize treatment problems, how to determine measurable goals, and what interventions work best to achieve measurable treatment goals.

2. A second recommendation based on the results of the practicum is to determine how administrative staff best aid an interdisciplinary team process. Can administrative staff lead an organization without interfering with the planning process of the interdisciplinary team? What types of decisions can interdisciplinary teams make and remain within administrative guidelines?

Dissemination

The success of the practicum has led to interest from directors of other residential facilities in the state. The writer intends to provide the results of the practicum to the directors wanting to implement an interdisciplinary team approach to treatment planning. Also, the writer will apply to the state association of non-profit residential agencies for permission to present the results of this practicum at an annual meeting in March 1992.

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APPENDIX A

INTERDISCIPLINARY TREATMENT PLAN

INTERDISCIPLINARY TREATMENT PLAN

DEMOGRAPHICS (at Intake)

Name ____________________________ Caseload Counselor ____________________

DOB __________________ Age ________ Supervisor ____________________________

ADM Date ______________________ Clinician ______________________________

Adm # ____________________ Teacher ______________________________

County Worker ______________________

Family: Mother ______________________________ Age __________

Father ______________________________ Age __________

Step Parent ________________________ Age __________

Will family participate in in program?
Yes No

Marital Status of Parents (circle): Intact Separated Divorced Never Married

Sibling(s)/Age: Whereabouts:

Other Significant Relatives/Adults:

BACKGROUND INFORMATION (at Intake)

Ethnic Background (circle):

Father:	Black	Caucasian	Chicano/Latino	Asian	Other: __________
Mother:	Black	Caucasian	Chicano/Latino	Asian	Other: __________

Religious Background (circle):

Father:	Protestant	Catholic	Jewish	Other: ____________________
Mother:	Protestant	Catholic	Jewish	Other: ____________________
Client:	Protestant	Catholic	Jewish	Other: ____________________

Special Education History:

Active IEP (circle): Yes No

If yes, Date of Last IEP ____________________

School Last Attended ______________________________ Dates __________

Grade __________

Special Education Eligibility (circle): SED LD Other: __________

If Resident is 16 years old, what are the basic vocational plan:

School Credits (to date): ______ No. Credits Needed to Graduate ________

Name________________________________ Date________________________

BACKGROUND INFORMATION (at Intake)

Psychological Testing on File (circle) Yes No

If yes: Date of last test____________________ Psychometrist__________________

IQ Scores: Verbal_______ Performance_______Full Scale_______

DSM-R Diagnosis:

Other Results:

Neuropsychological Testing on File (circle) Yes No

If yes: Date of last test______________________Psychometrist____________________

Results:

Significant Medical Concerns:

Previous Placement History: (including psychiatric hospitalization)

Family Situation:

Name________________________________ Date_____________________

Abuse/Neglect:

Alcohol/Drugs:

Education/Vocation:

Other Significant Issues at Intake

Discharge Plan at Intake (include anticipated date of discharge):

Name__________________________ Date_______________

30 DAY PRESENTING PROBLEMS

Behavioral Issues:

1-Disagree/Not a problem
2-Not a significant concern/problem
3-No opinion/No information/More information is needed
4-A potential problem/A concern to be addressed
5-Agree/Highly probable/possible/Needs to be addressed immediately

_____Impulse Control
_____Physical Acting Out
_____Verbal Acting Out
_____Runaway
_____Authority Issues
_____Drug Abuse
_____Alcohol Abuse
_____Other:________________________

_____Sexually Molested
_____Sexual Acting Out
_____Problems w/Family Members
_____Gang Issues
_____Destruction of Property
_____Stealing
_____School Problems--Specify (circle): LD SED

Family Issues:

_____Parents Divorced
_____Mother Not Involved
_____Father Not Involved
_____Client Adopted
_____Parent Addiction
___Past ___Present

_____Stepmother
_____Stepfather
_____Child Abused by Parent(s)--Specify:_______
_____Other:__________________________________

Psychotropic Medication: Date prescribed_____________
Prescription___________________ Dosage_________

Symptoms Prescribed for:

Possible Side Effects:

Other Significant Medical Issues:

Name________________________________ Date_______________________

THIRTY DAY PRESENTING PROBLEMS--CLINICAL ISSUES (continued)

Diagnosis: Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

_____Abandonment Issues
_____Abandonment: Who
When
_____A.D.H.D. Past/Present
_____Alcohol Abuse
_____Anger Control
_____Anxiety
_____Authority Issues
_____Communication Skills
_____Death Of Signif. Other
_____Depression
_____Drug Abuse
_____Emaciated
_____Family Violence
_____Frustration Tolerance
_____Gang Issue
_____Impulse Control
_____Irresponsibility
_____Language Barriers
_____Low self-esteem
_____Other Clinical Issues

_____Lying
_____Manipulative
_____Oppositional
_____Passive/Aggressive
_____Past Episode of Psychosis
_____Peer Relationships
_____Pre Psychotic
_____Problems w/Family
_____Processing Issues
_____Problem Solving
_____Psych Hospitalization
_____Runaway
_____Sexually Abused
_____Sexually Abusive
_____Staff Relationship
_____Suicide Attempt
_____Temper Tantrums
_____Trust
_____Withdrawn

Working Diagnosis:

Long Term Goals:

Psychotropic Medication: Date Prescribed__________________
Prescription_______________ Dosage________________

Symptoms Prescribed for:

Possible Side Effects:

Past Psychotropic Medications:

Other Significant Medical Issues:

Name______________________________ Date__________

30 DAY PRESENTING PROBLEMS--EDUCATIONAL/VOCATIONAL ISSUES (continued)

IEP Progress

____ Initial ____ Interim

Meeting Held: ______________________

If yes, Eligibility: SED Communicative Disorder

(Circle) LD Processing Disorder

If no, Comments: ____

____

Accountabilities

____ Attends School Regularly # of Absences: Excused ______

Unexcused ______

____ On time to class # of Tardies: __________

____ Office Referrals # of Referrals: __________

If yes, describe: ____

____

____

Resolved? YES NO

____ Suspensions # of Suspensions: __________

If yes, describe: ____

____

____

Resolved ? YES NO

School/Class Rules

___ Respects school/other's property

___ Refrains from cursing/swearing

___ Avoids fights/arguments

___ Show's respect for adults/self

___ Follow's directions from all staff

___ Doesn't steal

___ Doesn't cheat

___ Gets along w/ others

Classroom Behavior

___ Demonstrates appropriate behaviors in large and small groups
  - ___ Is not demanding
  - ___ Stays in seat

___ Demonstrates adequate attention span in large and small groups
  - ___ Is restless
  - ___ Is distractable
  - ___ Is quarrelsome
  - ___ Makes noises
  - ___ Daydreams

___ Asks for help when it is appropriate

___ Begins/completes assigned work on time

___ Tries to complete a task before giving up

___ Able to accept or respond to feedback appropriately

___ Accepts apologies from peers

___ Is easily influenced by others

___ Deals with anger appropriately

___ Copes with frustration/conflict situations

Name______________________________ Date______________________

30 DAY MILIEU PLAN

Problem	Goal	Intervention	Time

Supervisor___________________________ Caseload Counselor________________________

Name________________________ Date________________

30 DAY CLINICAL PLAN

Problem	Goal	Intervention	Time

Clinician________________________ Caseload Counselor____________________

Name______________________________ Date____________________

30 DAY EDUCATIONAL PLAN

Problem	Goal	Intervention	Time

Teacher__________________TA___________________Caseload Counselor_______________

Name______________________________ Date__________________

Treatment Plan approved by:

Name__________________________________ Title________________________ Date__________

Name__________________________________ Title________________________ Date__________

Name__________________________________ Title________________________ Date__________

Name__________________________________ Title________________________ Date__________

Name__________________________________ Title________________________ Date__________

Name__________________________________ Title________________________ Date__________

Name__________________________________ Title________________________ Date__________

Name__________________________________ Title________________________ Date__________

Name__________________________________ Title________________________ Date__________

Name__________________________________ Title________________________ Date__________

Name__________________________________ Title________________________ Date__________

Name__________________________________ Title________________________ Date__________

APPENDIX B

QUESTIONNAIRE REGARDING HOW THE INTERDISCIPLINARY TREATMENT TEAMS WILL MAKE DECISIONS

HOW THE INTERDISCIPLINARY TEAM WILL MAKE DECISIONS

On Wednesday, July 3, 1991, the three new interdisciplinary teams will be meeting for the first time. Please complete the tasks listed below and return one copy of the completed form to the director after the meeting.

The first task is to meet as a team. Initial staff roles have been discussed during the last couple of months. This is a time for the team to get acquainted and to talk about team goals.

These goals may vary from team to team, but all three teams have a consistent duty of providing interdisciplinary planning.

Remember, each member of the team has an equal voice. The task of the group is to assure that every member has ample opportunity to make suggestions, ask questions, and initiate treatment goals. Talk about these issues and come to consensus on how the team will function. In the future, each team will be required to develop and review a treatment plan for each resident every five weeks.

QUESTION

How will the team make decisions? By team consensus or by a majority vote?

APPENDIX C

QUESTIONNAIRE DEFINING STAFF ROLES IN THE NEW INTERDISCIPLINARY TREATMENT TEAM APPROACH

STAFF ROLES IN THE INTERDISCIPLINARY TEAM APPROACH

On Wednesday July 10, 1991 the new interdisciplinary teams will will meet for the second time.

The task for today's team meeting will be to further define individual staff member roles. Use this time wisely. You should be finalizing all aspects of how your team will operate.

Appoint someone in the team to respond to the questions below and return the completed form for you team to the director.

QUESTIONS

What are the specific duties of the team leader?

What are the specific duties of the caseload counselor?

What are the specific duties of the teacher?

What are the specific duties of the teacher assistant?

How will the team utilize the expertise of the psychiatrist, psychologist, school social worker, and other members of the staff who do not participate regularly in your weekly meetings?

APPENDIX D

QUESTIONNAIRE REGARDING THE USE OF THE NEW INTERDISCIPLINARY TREATMENT PLAN

USING THE NEW INTERDISCIPLINARY TREATMENT PLAN

During the general staff meeting, the director of treatment and senior clinician will present the new Interdisciplinary Treatment Plan. After this 30 minute in-service training, the three teams will meet. By this time, lines of communication and areas of responsibility for each member of the team should be fully defined, and the team should be ready to review the first three residents (beginning, Wednesday July 24, 1991).

Please discuss the questions on this form and have someone on the team respond. Remember to return a copy of your team's responses to the director.

QUESTIONS

How will you team complete the new Interdisciplinary Treatment Plan?

Who will be responsible to assure that a copy of the complete plan is in the residents' treatment file and school file?

Will each member of the team be responsible for individual sections of the plan prior to the treatment review, or will the team revise, amend and write a new treatment plan after the treatment review?